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The Ethics and Politics of Health-Care Resource Allocation

by

Anita Tsz-Shan Ho ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Doctor of Philosophy

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To My Family

Abstract

This thesis examines what an ethical health-care system should look like in a pluralistic state. It investigates how people who are from different economic or social backgrounds and have diverse experiences can come to agree on a health-care system that is fair to all. It argues that a deliberative democratic process that encourages equal civic participation is the best process to determine the fairest health-care scheme. This decision-making process, which is inclusive, participatory, empowering, reciprocal, and public, allows citizens to engage in dialogues with each other in determining a health-care system that is acceptable to all. This process allows people of diverse experiences to be more informed and provides them a valuable chance to communicate with each other their respective concerns. It ensures that no one is left out in the decision-making process.

I argue that when citizens of different economic and social backgrounds are given an equal chance to deliberate with each other, they will likely realize that a multi-tiered system is the most acceptable system. In this system, the government provides universal basic health care to all, while allowing people to purchase various insured and uninsured services in the private market. Such a system ensures that people will not die prematurely, lose their equal opportunity range, or suffer from excessive pain because of poor economic status. It also protects taxpayers' autonomy by allowing them to use their disposable resources as they see fit.

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TABLE OF CONTENT

INTRODUCTION 1

CHAPTER ONE:

A RIGHT TO HEALTH CARE? 9
Rights 11
Needs 22
A Rawlsian Right to Health Care? 27

CHAPTER TWO:

PROBLEMS OF "NEEDS" AND "RIGHTS TO HEALTH CARE" 36
Libertarians' Objections to the Theory of Needs 37
What About Social Constructionism? 39
Social Construction of Disability 44
Libertarians' Response 48
Social Constructionists' Responses to Libertarians 49
Problems of Prescriptive Needs Statements 54
Other Problems of the Rights Language 58
Conclusion 66

CHAPTER THREE:

THE NEED FOR A DELIBERATIVE PROCESS 67
Atomist Individualism and Libertarianism 68
Contractual Theory of Obligation 69
Reasons for Using Consent/Contract as Ultimate Basis for Enforceable Obligation 74
Reasons for Dissent 76
Necessity of an Alternative Political Decision-Making Process 79
The Alternative Political Decision-Making Process --
The Inclusive Deliberative Approach 82

1. Inclusion 85
2. Participation or Deliberation 87
3. Empowerment 93
4. Reciprocity 95
5. Publicity 96
Objections to the Inclusive Deliberative Approach 97

CHAPTER FOUR:

DELIBERATION ON TAX-FUNDED HEALTH CARE 107
Goals of Establishing Tax-Funded Universal Health Care 107
Deliberation on Tax-Funded Universal Health Care 108
Rejection of Pure Market Approaches 109
Tax-Funded Health Care and the Rich 116
The Transformative Deliberative Process 120
The Rich Dissenters 124
A Right to Do Wrong? The Social Good and Fairness Arguments 127

CHAPTER FIVE:

WHAT SHOULD WE FUND? 133
Determining the "Decent Minimal Level" 133
I. Prevention of Premature Deaths 136
II. Restoration of Normal Species Functioning and Opportunity Range 139
III. Prevention of Diseases and Injuries 142
IV. Relieving Excessive and Prolonged Pain and Suffering 147
What Services Should a Deliberative Democratic State Fund? 151
The Criterion of Efficacy 152
Comparative Cost-Efficiency and Prioritization 153
Expensive but Beneficial Interventions 157

Problem of Responsibility 159
What Else Can We Do? 166

CHAPTER SIX:
THE MORALITY OF MULTI-TIERED SYSTEMS 167
Multi-Tiered Systems and Unequal Access 168
Fairness and Equality: Do They Require Uniform Access? 169
Private Market for Uninsured Services 171
Basic Equality 171
Protection of Autonomy and Unequal Access 173
Consistency Argument 174
Conceptual Difficulty and Practical Concern 175
Purchasing Insured Services in the Private Market 177
Issues of Equality of Respect and Concern 179
Consistency Argument Revisited 182
Effects of the Private System on the Public System 183
Egalitarianism of Envy and Egalitarianism of Altruism 187
Difference Principle and Multi-Tiered Systems 190
The Hong Kong Example 193

CONCLUSION 197

BIBLIOGRAPHY 203

INTRODUCTION

This thesis is about what an ethical health-care system should look like in a pluralistic democratic state that values people's autonomy. It provides an account of how citizens who are in different social and economic conditions and have different moral visions can come to agree on a health-care system. While citizens of a pluralistic state will need to make various kinds of policy decisions, for the purpose of this thesis I only focus on the issue of resource allocation. Nonetheless, the decision process I propose can also apply to these other health-care and social policies.

Let me first explain the context on which my discussion is based. This project deals with how *citizens* in a *democratic* society may come to decide what kinds of health-care allocation policies should be adopted. Such a state respects its citizens' autonomy and realizes the importance of public input in enacting various policies. Nonetheless, the democratic state that I shall propose differs from many contemporary "democratic" nations and the models proposed by some other writers on democracy. First of all, most democratic writers argue for representative governments. They seem to think that a political process is "democratic" if it is made up of elected officials who will make decisions on behalf of their voters. I shall argue that a decision-making process that relies totally on elected officials is not truly democratic. While the people's voices are supposedly heard through the voices of the elected officials, in reality citizens often have little power to influence the outcomes of political processes. In fact, even though elected officials are presumably acting on behalf of or representing their voters, we sometimes wonder if these officials hold an accurate view of public opinion. Moreover, very often these officials "represent" not only those who voted for them, but also those who did not vote for them or even voted against them. There may therefore be additional questions of how "representative" these "elected" officials may be. To counter these problems, I shall argue that a truly democratic state ought to encourage not simply representative government but more importantly civic participation. In other words, the democratic state that I shall propose takes more seriously the deliberative capacities of *citizens* themselves. While I do agree that representatives are often helpful in facilitating deliberations and implementing policies, they should not replace the citizens in democratic deliberations. Civic deliberation can help citizens and officials become more informed about various issues and other people's perspectives. There is also something intrinsically valuable about citizens deliberating with each other on various issues and making policy recommendations themselves. It can help create a social community that unites fellow citizens, and such common bond can facilitate respect and accommodation of diverse opinions.

The democratic process that I shall propose is also different from other contemporary liberal processes in another way. When citizens in these liberal democratic processes do speak out or "participate" in the political process, they usually do so by means of secret ballots and simple opinion polls. While such mechanisms seem to allow people to tell public officials their concerns and interests, very often people who cast their votes and give their opinions have little knowledge or understanding of the issues involved. People may not be informed about the various issues involved, and they also may not have thought through these matters before providing their opinions. Most of the time citizens are not given the chance to engage in dialogues with each other to understand their respective concerns and the polls are usually too superficial to obtain any meaningful information. In the end, the results of such polls do not give us a real sense of how people reach their decisions and what they may really want. Given that poll results do not indicate why people vote in certain ways, they do not help people to understand the full picture.

I propose that a pluralistic state that values people's autonomy and their input in making public decisions can solicit meaningful consent and opinions by employing an inclusive deliberative approach. Such an approach allows people of various backgrounds to participate with each other in making political decisions. It provides an opportunity for people to become more informed about various issues and a chance to reflect with each other their respective concerns. This participatory approach in the end allows the citizens to find out not only what opinions people hold, but also why exactly they hold these opinions. For example, in dealing with the issue of health-care resource allocation, the deliberative democratic process allows reflective citizens to discuss with each other their concerns.

This inclusive deliberative approach provides an open environment for people from different backgrounds to discuss their diverse concerns and work with each other in reaching agreements. This is very important in a democratic state. After all, despite disagreements, any society still needs to decide on various policies. If citizens in a pluralistic state have to abide by the same polices, they should employ a process that treats disagreements seriously and reviews various possibly opposing positions fairly.

This deliberative democratic approach for which I shall argue is modelled on Amy Gutmann and Dennis Thompson's (1996; 1999) deliberative process. This approach is preferable to many other political approaches. First, unlike other democratic theories that rely heavily on representative governments, this deliberative approach addresses the importance of civic participation. Second, it provides an alternative way to resolve issues that cannot be adequately dealt with by broad principles. Many philosophers who deal with the issue of health-care resource allocation assume that deliberation is unnecessary in resolving allocations. They believe that they can simply employ various principles of justice in trying to come up with a health-care system that is fair to all (Green, 1976; 1983; Daniels, 1983; 1985). However, it seems that justice principles are often too vague to provide clear guidance on how we can resolve various allocation dilemmas in a pluralist state, such as how much and what exactly we have to provide. The democratic approach I shall propose allows people to work with each other to reach consensus.

While Gutmann and Thompson (1996; 1999) do briefly comment on the issue of health-care resource allocation, they do not provide a detailed or systematic account of how reflective citizens in a democratic state may deliberate with each other on this issue. My thesis is an attempt to further develop some of their arguments and apply this democratic deliberative process to the issue of health-care resource allocation to see what an ethical health-care system might look like in this pluralistic democratic state.

My thesis also helps to fill a gap in the Canadian literature of health-care debate. While discussions on health-care reform have sparked numerous political debates on "multi-tiered systems," there have not been many philosophical discussions of what constitutes a multi-tiered system and whether such a system can be justified on moral grounds. Certainly, there have been numerous newspaper articles arguing either for or against multi-tiered systems. However, most of these writers do not define what a multi-tiered system is. Without specifying the characteristics of the system at stake, we simply cannot evaluate the arguments for or against such a system. I shall provide an analytical discussion of multi-tiered systems and argue that certain kinds of multi-tiered systems are morally justifiable.

For the purpose of this thesis, I only concentrate on how the deliberative parties will likely reflect on the issue of health-care resource allocation. In particular, I focus on the issue of health-care funding. I shall argue that deliberative citizens will reflect with each other on issues such as the goals of health care, reasons for and against establishing tax-funded health care, and the kinds of health-care services that they may or may not want to fund. Although I will not go into details in discussing how reflective citizens may deliberate on non-funding issues, I contend that the parties will probably use the same process to decide allocation issues regarding other medical resources, such as organs, health-care personnel, and so on. These reflective citizens will also likely use the deliberative process to make other political decisions. For example, they will probably discuss with each other and then make funding decisions on a meta level, such as what proportion of the tax dollars should go into health care versus other social goods. They will also deliberate together to mutually decide on the amount of taxes they can legitimately collect. While I discuss some of these issues in passing, I do not focus on any of them. I acknowledge that a more comprehensive project on how the deliberative principles may work in the democratic state will need to address such matters.

The first chapter starts with the notion of "right to health care." Ever since the World Health Organization and the United Nations respectively declared that people have a right to the highest attainable standard of health and health care in 1940s, the slogan "right to health care" has been widely heard in election debates, public-opinion polls, and so on. As one writer observes, discussions of contemporary health-care policy "are replete with claims about justice or equity in health care allocations and rights to treatment" (Bole, 1991, 1). Many have used such a notion of health-care rights to support their arguments for tax-funded health care. Chapter 1 examines the arguments for a right to health care. It provides a brief expository account of what philosophers mean by rights, and how we may categorize different kinds of rights, including the alleged right to health care. It discusses the notion of objective needs, a notion that some believe is central to the idea of welfare rights.

Chapter 2 evaluates the notion of objective needs and welfare rights. It begins with a presentation of two arguments against the notion of objective needs. The first argument, presented by libertarians, focuses on how individuals in a pluralistic society have different moral visions and life goals. Assuming that needs are goal-specific, libertarians argue that people's conceptions of their needs and how they should fulfil these needs also differ. The second argument, presented by social constructionists, attacks a specific implication of the assumption that people all share the same needs. It argues that the uncritical assumption that needs are objective has led to the belief that people can decide for others what they need. This chapter also draws attention to the different conclusions reached by libertarians and social constructionists. While libertarians conclude that we should abandon the needs language, social constructionists believe that we can still legitimately talk about needs and allow the possibility that only people themselves can interpret their needs. This chapter ends with a discussion of various problems of the idea of "right to health care." It argues that such a notion poses more questions than it answers, and therefore cannot serve as a solid foundation for a publicly-funded health-care scheme.

Chapter 3 presents the libertarian argument against coercive redistribution and proposes an alternative approach to make allocation decisions. It examines how the libertarian atomist understanding of individuals leads to the idea that obligations only arise out of contracts or explicit consent. While I agree that respect for autonomy is important in a democratic state, it does not imply that we have to take assent or dissent at face value. We can still legitimately distinguish rational from irrational dissent, and try to find a way to design policies that can reasonably be accepted by the public. I argue that a deliberative process that is inclusive, participatory, empowering, reciprocal, and public can help citizens to reach overlapping consensus on what policies should or should not be implemented. These five criteria set up the constitutional structure of the democratic process. Since these criteria themselves constitute the framework for the deliberative process, they are not subject to deliberation or negotiation. Any political process that does not have all of these five criteria simply is not a democratic one.

Such a deliberative democratic approach encourages people to reflect with each other their respective concerns and interests. I argue that such a process is the best way to solicit meaningful consent from reflective citizens. It is also a promising way to secure cooperative schemes, since people who see themselves as part of a polity will likely see each other not as complete moral strangers but fellow citizens who co-contribute to the same polity and will be bound by the same laws. They will also likely start to care about their fellow citizens and see their self-interest not in an egoistic but incorporative way. People who have compassion for their fellow citizens will incorporate others' concerns in thinking about what is in their interest. When they see themselves as part of a polity, they will see promoting the social good as part of their own interest.

Chapter 4 examines how deliberative parties will likely decide on the matter of a tax-funded health-care scheme. It starts out by arguing that people who want affordable health care have good reasons to support a tax-funded scheme. At this point people may have a fairly narrow understanding of their self-interests. They may only think about how they can get affordable health care for themselves and their loved ones. However, once they start reflecting with each other as fellow citizens on how a tax-funded system may affect them personally, they will start to see how the availability of affordable health care may also affect others. When people deliberate with each other, they may no longer see others as moral strangers but as members of the same social community. Realizing that their fellow citizens are also bound by the same allocation decisions, the deliberative citizens are more likely to think about not only their narrow self interests but also others' interests. It may now be important for them to establish a health-care system that is not only affordable for themselves but also for their fellow citizens. In other words, they may now care not only about whether they and their loved ones have access to affordable health care, but also whether their fellow citizens have access to it. They may also see promotion of a healthy population as part of their own goal. In this way, after reflective deliberation with other members of the community, people will probably agree to redistribution to finance a health-care scheme that can not only benefit themselves but also others in the polity.

For those who may still dissent, I argue that the deliberative parties do not have to accept their dissent as an indication that the government cannot legitimately charge *any* amount of taxes to finance the public scheme. After all, the notion of a right can still allow limits to the scope of the right. The facts that the deliberative process is fair and that health care is an important public good that requires general contribution provide two justifications for coercing these individuals to contribute their fair share.

Having established in chapter 4 that tax-funded health care is legitimate in a deliberative democratic state, chapter 5 examines what kinds of services the deliberative parties will want funded by the public scheme. I do not discuss how the parties may decide on the moral virtues or vices of various medical practices and thus whether such practices should be legal, although I contend that an inclusive deliberative process can help reflective citizens to reach these decisions. I only concentrate on how reflective citizens may decide on the funding issue. I suggest that the deliberative parties will likely agree with me that health-care services that are necessary to restore functioning and opportunity ranges, prevent premature deaths, prevent diseases and injuries, and ameliorate pain and suffering, should be funded by the public scheme. I also propose other factors that may contribute to their "rationing" decisions, such as the issues of responsibility and expensive treatments.

Chapter 6 examines the issue of whether the deliberative parties will allow private health care. While the preceding chapters concentrate on what the government of a deliberative democratic state should provide, this chapter focuses on what this government can or cannot legitimately prohibit. I argue that, once the deliberative parties have agreed on a range of health-care services to be provided in the public scheme, they will likely agree with me that people should be allowed to purchase insured and uninsured health-care services in the private market. Allowing people to purchase private health care is important partly because the public scheme will not be able to provide all medical and health-care services, perhaps because they are too morally controversial to be agreed upon by all deliberative parties, or perhaps because they are too expensive. Given that having reflective deliberation is valuable partly because people's autonomy is important, deliberative parties will not want the state to overly restrict people's freedom. They will probably mutually agree that people should be allowed to buy certain services in the private market, even if these services are not affordable for some people. In this chapter, I shall also argue against the assumption that multi-tiered systems that allow private medicine necessarily disadvantage the indigent. I shall use the example of Hong Kong to show that a well-run multi-tiered system can be beneficial to all.

The concluding chapter acknowledges some limits of the deliberative process in reaching "universal" decisions. It shows that decisions reached by the deliberative process should be treated as provisional, subject to further deliberations and possible revisions. Such a provision acknowledges the possibility that certain important information or arguments may have been ignored or missed by the deliberative parties for whatever reasons. It provides a mechanism for the reflective citizens to "reopen" their case.

I accept that my proposals and suggestions are not conclusive or definite. While I think reflective citizens who deliberative with each other under the conditions I propose will likely agree with my suggestions, it is conceivable that the deliberative parties may reach decisions that differ from my suggestions. However, I do not see this to be a flaw of the deliberative process. Rather, it simply shows that meaningful deliberation has to engage different social groups to converse with each other in reaching results that can be mutually accepted.

CHAPTER ONE

A RIGHT TO HEALTH CARE?

The World Health Organization (WHO) in 1946 stated that the "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being" (World Health Organization, 1958, 459).[1] Two years later, the new United Nations (UN) stated in its Universal Declaration of Human Rights that everyone "has the right to a standard of living adequate for the health and well being of himself and his family, including ... medical care ..." (Nickel, 1987, 185). Since then, there have been frequent debates on the idea that "health care is a right." As one writer says, the phrase has a forceful ring to it and makes a fine slogan (Singer, 1976, 175). Others have also commented that a right claim constitutes perhaps the strongest of all moral claims that one can assert, since "the appeal to a right on one side of an issue must be countered by some equally potent weapon on the other" (Sumner, 1987, 8). As one writer has said, reformers cannot demand our beneficence in the same way as they can demand our attention to rights (Moskop, 1983, 330). Rights often have a special status that includes a priority over the ordinary goals of the state (Copp, 1992, 233; 1998, 127). Both Ronald Green (1979, 1983) and Norman Daniels (1985) have argued that health care is a right that justifies coercive redistribution of resources to provide universal health care. In this chapter, I shall explain how some philosophers have come to the conclusion that we have a right to health care. I shall leave the evaluation of such arguments to the next chapter.

Although most people will agree that basic health is important, since it is necessary for anyone to pursue his or her life goals, whether that implies access to *health care* as a *right* is controversial. Certainly, if we are asking whether health care is a legal right, then we simply need to see if the government has directly or indirectly promised to provide health care to all.[2] However, most discussions of the right to health care focus on the issue of moral right. Many who argue that health care is a right believe that it is a universal human right that exists prior to or independently of any legal or institutional rules conferring such a right. In fact, they sometimes argue that such a moral right provides a reason why it ought to be protected or even promoted by the legal system or institutions. Some believe that the alleged existence of a right to health care provides the ultimate justification for pressuring the government to establish a public health-care scheme to provide universal access to various health-care services.

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[1] The World Health Organization (1958) defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (p. 459). As we shall see in the next chapter, this definition may be too broad to guide resource-allocation policies.

However, not everyone is convinced that the rights language is helpful. While this language is often used as "a tool of persuasion," some believe that it is simply a language of rhetoric, without substance. As we shall see later in this chapter and again in the next chapter, the concept of a *positive* right to health care can be more confusing than helpful. This notion is a tricky one partly because it seems to restrict some people's liberty.[3] In order to benefit other people, the concept of a positive right to health care requires that some people take certain positive steps to provide others with some resources. For example, if there is a universal right to health care, people may be required to contribute some of their resources to finance a public system that provides universal access to various health-care services. They may be obligated to contribute even if they do not wish to use the public system or would rather spend their resources on other things.[4] In this way, people do not have total control over how their resources are being spent.[5] As we shall see in the next chapter, it is unclear whether a positive right to health care demands more than provision of monetary resources to set up various health-care facilities to provide services. For example, it is unclear whether it also allows or demands "drafting" medical professionals and forcing them to treat patients. It is also unclear if it permits or requires people to "donate" their organs to help those who need organ transplants. We will also see in the next chapter that libertarians such as Engelhardt (1996) argue that the 'creation' of welfare right to health care, which restricts individual autonomy, is illegitimate.

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[2] Without going into detail, I contend that the government may have indirectly promised to provide universal health care if it has signed various international declarations, including the WHO and UN treaties cited earlier.

[3] As we shall see later, restricting people's liberty does not necessarily imply *violating* their liberty. Judith Jarvis Thomson (1977), for example, argues that there are situations where we may legitimately restrict people's freedom.

[4] As we shall see in chapter 3, libertarians do not believe that people have any obligation to contribute if they do not wish to do so. Their contractual theory of obligation argues that people have obligations to do X only if they have entered into an agreement with others that they would do X.

Rights

Before we can understand and evaluate the notion of a right to health care, we must first examine the general meaning of having a right. A complete analysis of various complex issues of rights is beyond the scope of this chapter.[6] For our purpose, a brief sketch of some of the issues will do.

There is a long tradition in political philosophy that supports the view that all persons possess some natural rights. Although it is difficult to determine when exactly the idea of natural rights emerged, such a notion was perhaps most widely used in early modern Europe. Hugo Grotius (1583-1645), who interpreted the universal impulse of self-preservation as a moral principle, thought that human beings all have a natural right to self-defense and to acquire the necessities of life. John Locke (1632-1704), who also employed the natural-right language, held the view that rights to life, liberty, property, and pursuit of happiness are inalienable to every human being.[7] The purpose of government is in part to protect these rights.[8]

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[5] As I shall argue in chapter 4, respect of people's autonomy does not imply that people have to have *complete* or *absolute* control over their property.

[6] For detailed contemporary discussions of the concept of rights, Feinberg (1973; 1979; 1980), Nickel (1987), Benditt (1982), and a collection compiled by Lyons (1979).

[7] For detailed discussions of the origin and development of natural-right theories, see Tuck (1979) and Tierney (1997).

It is worth noting that this natural-right tradition is theologically based. People are said to have these inalienable rights because they are endowed by their *creator* with such rights.[9] For example, Locke thought that God gave humans a strong desire to preserve their lives and provided other inferior creatures for our use.

While the notion of inalienable rights is still popular in contemporary political philosophy, many philosophers have abandoned the religious overtone. Given plurality in religious and cultural beliefs, many rights theorists acknowledge the difficulty of grounding moral rights in particular theology. When there are many competing religious viewpoints, it is difficult, if not impossible, to show that there are inalienable rights enjoyed by all "creatures of God."[10] As Engelhardt (1996) says, "all do not listen to the Deity, or listen in the same way" (p. 36). If we do not all have the same access to the theistic moral truths, we simply cannot legitimately base a natural-rights theory on such a theistic notion. Employing such a notion authoritatively and imposing it on everyone regardless of their religious beliefs may therefore be problematic. As we shall see later, Engelhardt argues that we cannot even arrive at any authoritative viewpoint secularly.

Many contemporary writers who share some of Engelhardt's concerns but still want to talk about universal rights have abandoned the theological approaches. Instead of talking about theistic natural rights, most rights theorists have switched to the term "human rights." Rather than talking about the source of these rights, they concentrate on the question of who possesses them. Even though these writers acknowledge that the basis of such universal

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[8] The ideas that human beings are endowed by their creator with various inalienable rights and that governments are instituted partly to protect these rights can also be found in the American Declaration of Independence of 1776.

[9] For the purpose of this chapter, I shall not discuss the issue of whether animals and other life forms are also endowed with rights.

[10] As we shall see later, Engelhardt is especially worried about the idea of there being one unique moral perspective available to secular reason because it may lead to the encroachment of state power on individual autonomy.

rights remains unclear, they think the important point is that all human beings possess them (Weinreb, 1992, 280).[11]

However, not everyone is convinced that we can have a theory of human rights without a sound argument for the source of such rights. While many contemporary writers who argue for secular human rights try to avoid talking about the source of such rights, their opponents are suspicious of such move. Those who do not accept this revised notion of human rights point out that there is a distinct source of these so-called human rights. The notion of a right, they argue, presupposes a system of social rules that are historically and culturally specific. In other words, the sources of these rights come from various social and political institutions. The rights that are supported by such institutions therefore cannot be considered *universal* human rights that are *independent* of these institutions. When people invoke the notion of human rights, they have something *political* in mind: they want to promote certain social goals or ideals. For example, one may argue that the UN and WHO manifestos only function "as a guide for progressive development toward both rights and material security, rather than as an assertion of prevailing rights or of natural and human rights in the classical sense" (Beauchamp, 1991, 56).

However, pointing out the source of the so-called human rights makes some philosophers even more suspicious of the legitimacy of using such a notion in political discourse. One writer contends that the language of human rights is "extravagant and vacuous at one and the same time" (Margolis, 1978, 354). He argues that various so-called human rights are "nothing but those most generic, so-called prudential concerns attributable to men, underlying all rational efforts to provide a moral justification for political, legal, economic, and related institutions" (Margolis, 1978, 355). To call these concerns human rights "is simply to favor one among a number of alternative views of their role in a political doctrine and program" (Margolis, 1978, 356). In other words, what count as rights depend not on an objective notion but on the political or cultural climate. As he says, "it is difficult to suppose that the natural right to health care is simply discovered as a result of straightforward inquiry of a securely nonpartisan sort" (Margolis, 1978, 354).[12]

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[11] One writer points out that the switch from the term "natural rights" to "human rights" reflects many philosophers' doubt as to whether nature is intelligibly the source of any normative principles at all (Weinreb, 1992, 279-280).

If so-called "human rights" are not objective rights held by everyone but created by some people for political purposes, one may worry about the implications of such "creation." As we shall see in the next two chapters, libertarians such as Engelhardt (1996) worry that the creation of welfare rights, which are often considered some of the most fundamental "human rights," may provide an excuse for some people and the state to violate other people's freedom and autonomy.

The question is, is it really impossible for us to establish a source or foundation of right-based morality, so that we have to admit or accept that rights are simply created by humans for various political purposes?

Those who argue for the existence and importance of human rights insist that social and political institutions are not the sources of human rights, but rather the bodies that are designed to protect or fulfil such rights. They claim that rights are justified requirements that all persons have as their due (Gewirth, 1987; 1996). These rights do not depend on whether these human beings are members of certain society that has some special institutions. As one philosopher notes, very often "we assert that someone has a right to something, even though we know there are no regulations or laws conferring such a right" (Feinberg, 1973, 84). The notion of human rights allows people to speak past existing institutions and invoke supposedly universal standards. According to this universal theory of human rights, not only are human rights independent of social institution; they in fact provide the mechanism that allows people to evaluate various institutions and the social order. For example, if we agree with the WHO and UN that every human being has a right to health care, then we can say that those societies that do not respect such a right are unjust.

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[12] As we shall see in the next chapter, social constructionists are worried about various concepts that are simply taken to be objective and discoverable in the natural world. One may echo Margolis (1978) and argue that health-care rights are not discoverable in the world but are created by various social or political practices.

Many philosophers who argue for right-based morality believe that we can derive rights from our notions of fairness. While these philosophers such as Ronald Dworkin (1977) and John Rawls (1971) do not directly argue for "human rights," they do think that certain things are owed to all people irrespective of their social and cultural circumstances. They argue that equal respect is due all people because they are human beings capable of making choices and forming life plans. Certainly, one may question whether this account of rights based on autonomy really captures respect for all people. After all, there are many human beings who are *incapable* of making choices and forming life plans, and an autonomy-based account of rights may not address the status of these human beings. Advocates of "human rights" in general believe that the source of people's rights is not their capacity to make choices. Even though some people are incapable of forming autonomous life plans, it seems that they should still enjoy equal respect from others. They have a right to be treated as equals simply because they are humans. In fact, advocates for "human rights" seem to think that those people who cannot form their own autonomous choices are most vulnerable and that an adequate account of human rights ought to address and minimize the vulnerability of these people. However, most philosophers who argue for such universal human rights in a secular context still fall short of explaining what the source of such rights is. There remains an uncertainty about which characteristics (such as capacities for sentience, self-reflection, and/or reasoning) are necessary or sufficient for possessing human rights. On the one hand, if non-universal human capacities are deemed necessary, then we have to redefine the term *universal* human rights and explain why those human beings who do not possess those characteristics should not be accorded the same rights. On the other hand, if such characteristics are irrelevant in determining the moral status of human beings, one has to explain why they are irrelevant. One also has to explain whether the same universal rights that apply to human beings should also apply to animals and other life forms. After all, if characteristics such as rationality or self-reflection have no bearing on whether some human beings should be accorded the same rights, one may argue that other life forms should also be treated with the same respect.[13]

One of the philosophers who argues for universal human rights is Kai Nielsen (1984), who admits that there are many unanswered questions about the human-rights approach. He even acknowledges the possibility that a belief in human rights and egalitarian justice may not be objectively justified (Nielsen, 1984, 38). However, that does not stop him from adopting such an approach. He employs the Rawlsian notion of reflective equilibrium[14] and argue that a right-based approach is morally superior to elitist theories that give certain human beings higher value.[15]

The question is, what makes the egalitarian approach of human rights superior to an elitist approach?

The universality characteristic is part of the reason why many philosophers believe that the notion of equal rights among all persons is appealing (O'Neill, 1986). It does not seem to depend on anything contingent and morally arbitrary, so it does not give certain individuals less respect because of something they cannot control. As we shall see later, liberals such as Rawls (1971) argue that political institutions should be designed in such a way to minimize undeserved disadvantages.

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[13] Some philosophers argue that if characteristics such as capacities to reason and feel pain and pleasure are not uniquely human or are irrelevant in thinking about equality among humans, then it seems that we have to extend at least some of the same human rights to other life forms. If we hold a prejudice toward the interests of members of one's own species against those of members of other species, it seems that we are unjustly discriminating other species by not considering their interests. For a detailed discussion of "speciesism," see Peter Singer (1990).

14 According to Rawls (1971), one has reached reflective equilibrium when one "has weighed various proposed conceptions" and "has either revised [one's] judgements to accord with one of them or held fast to [one's] initial convictions" (p. 48).

[15] Nielsen (1984) employs Nietzsche's theory as an example of the elitist approach. Nietzsche believes that the common men with "slavish mentalities" are expendable for the benefit of achieving higher civilization. In this way, he completely rejects the egalitarian idea of treating all persons as equals who are of equal worth.

Another reason why an egalitarian notion of rights is attractive is that it protects people's self-respect. Nielsen, for example, argues that when people are in equal condition, there is no power asymmetry and so everyone has the same respect. No one has power or control over another, so they are all treated equally as moral persons with equal moral worth. In fact, the egalitarian conception of human rights helps to empower those who are in unfortunate situations. These rights allow them to claim equality in an otherwise very unequal situation. Rights provide a mechanism for individuals to challenge those who want to exploit them or keep them in inferior conditions.

The third reason why the notion of human rights seems appealing is that it seems to carry strong moral force. As James Nickel (1987) and David Copp (1992, 1998) point out, rights are not simply high-priority goals. While high-priority goals may be aspirational and indefinite,[16] they can be deferred when prospects for success or progress seem dim or when other opportunities are present or can lead to a greater benefit overall (Nickel, 1987; Dworkin, 1977). Goals can be compromised for the sake of other goals (Dworkin, 1977). In other words, high-priority goals are not binding. Rights, however, are of a different nature. They are not only definite, but are also binding or mandatory (Nickel, 1987; Copp, 1992; 1998). This characteristic of rights is captured by Ronald Dworkin's (1977) notion of rights as "trumps." Rights characterized as trumps imply that having a right to something can *generally* prevail in competition with other concerns such that they can outweigh other claims to that thing. According to Dworkin (1977), rights are so powerful that they are to be overriding and enforced even at a loss to public utility. As he says, "it follows from the definition of a right that it cannot be outweighed by all social goals" (p. 92).[17] The claim that human beings have a right to health care thus provides an important rhetorical device for those who argue for fulfilling health-care needs.

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[16] By "definite," Nickel implies that goals can specify who will receive a certain mode of treatment and who will act on specific occasions to make that treatment available (Nickel, 1987, 17).

[17] We need to be careful with Dworkin's (1977) characterization of rights as trumps, since he does *not* say that rights *always* prevail *all* other goals. While Dworkin does not think that a right can be "defeated by appeal to any of the ordinary routine goals of political administration," he does allow it to yield to another right or "a goal of special urgency" (p. 92). As we shall see in subsequent chapters, this possibility that other prevailing

This binding character of a right provides a basis for complaint when the right is not respected. The rights holder may demand an explanation or justification for why his or her rights are not fulfilled. If one's rights are abridged without justification, one is being wronged (Copp, 1992). As Tom Beauchamp (1991) says, when an appeal to rights is made, a response is demanded, and we must accept the person's claim as valid or discredit it by showing how it can be overridden by countervailing considerations or competing rights claims.[18] In other words, rights can be understood as justified claims or entitlements such that a rights bearer can make demands.

An example may illustrate the difference between high-priority goals and rights. Suppose various members of a community explicitly committed themselves to the goal of providing health care for everyone in the community. They launched fundraising campaigns and asked corporations to sponsor their cause. However, in spite of their best efforts, they could not raise enough money to set up a universal health-care plan. These members of the community thus decided to put their energy into other projects, such as decreasing the pollution level. They also decided to ask the donors for permission to use the raised funds to finance such project. If providing health care was simply a high-priority goal, the members of the community who decided to give up their goal did no wrong. However, if human beings all have a right to health care, the government or other organizations and individuals are mandated to respect such a right, or to make sure that someone or some organizations are fulfilling this right.[19] It implies more than just saying that it would be bad or unfortunate if

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considerations may limit the scope of a right may allow us to say that even if people have property rights, there may be situations that allow or even demand limitation of such rights.

[18] Once again, it seems that a right is not an absolute guarantee. We still need to see if there are countervailing considerations.

[19] I shall discuss the issue of what this right actually entails in the next section. As we shall also see in the next chapter, one of the problems that rights theorists face is who exactly is bound to fulfil the alleged right to health care.

human beings have no access to health care. It also implies more than saying that it would be highly desirable for all human beings to have access to health care. It stipulates that it is a justified claim or entitlement such that a rights bearer can make demands. Many political philosophers link the issue of right to the concept of justice. Denying someone that to which he has a right is often considered an injustice. If there is a right to health care and the community or government fails to respect or recognize such a right, an injustice has occurred.[20]

This last point brings out another feature of rights. It is often said that a right as valid claim "can be urged, pressed, or rightly demanded against other persons" (Feinberg, 1973, 58).[21] In other words, rights are often correlated with duties that must be observed by others. While "in personam rights" are rights that are "correlated with specific duties of determinate individuals," "in rem rights" are rights that are correlated with duties of "the world at large," i.e., everyone (Feinberg, 1973, 59).[22] One question that we will examine in the next chapter is whether this so-called right to health care is an in-rem or in-personam right.

Bearing this preliminary account of rights in mind, we can now discuss what people think is required to respect an alleged right to health care. When people say that we have a right to health care, they usually think of this right as a welfare right, which is a right against others to contribute to our welfare. Put in a different way, when one has a welfare right, one is entitled to be helped by others when facing hardships. A right to health care described as a positive welfare right implies that one is entitled to have access to health care, and that others have an obligation to do something to help one get such access, for example, to contribute to tax-funded health care.

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[20] However, what complicates the issue is that the organization or institution may find it impossible to fulfil this right. For example, if the government of a poor country cannot establish universal health care because it does not have the resources to do so, it is unclear that it has violated the right of its citizens. As many have argued, 'ought' implies 'can.' The government ought to provide health care, regardless of whether we call it a right, *only* if it can. So even if we consider access to health care as a right, this right depends on available resources and has to be balanced against other possible uses of those resources.

[21] Onora O'Neill (1986) also contends that the correlativity principle is the most fundamental structural feature of action-centred ethical reasoning. When we talk about rights, we usually assume a framework in which performance of obligations can be claimed.

[22] In personam rights are typically positive rights that require someone specific to *do* something. An example is an accountant's right to collect her fees from her clients, who have the duty to pay her. In rem rights are generally negative rights that require others' omissions or forbearances. An example is a landowner's right to use his own property exclusively such that everyone has a duty to keep off his property without his permission.

What is controversial about this concept of a welfare right is its *positive* nature. As a positive right, a welfare right requires people to do something to facilitate other people's pursuits, regardless of whether they want to support such pursuits or not. This may be problematic, since many people believe that we (also) have liberty or negative rights. Liberty or negative rights are rights to be free from interferences. They are "rights not to be done to by others in certain ways" (Feinberg, 1973, 88). Claiming that one has a negative right is to claim that one is free to do what one wants without being interfered with by others and that one has no obligation to do otherwise.[23] Such rights are often considered to be the most basic rights. As Hart (1979) says, "if there are any moral rights at all, it follows that there is at least one natural right, the equal right of all men to be free" (p. 14). In other words, the most basic right that we can have is one that allows us to resist someone else's interference except to hinder coercion or injury on others.[24] Having such a right limits what others may do to me. So if I acquired my resources through legitimate means and wanted to spend it on vacation and movies, I should be free to do so. Others have an obligation not to interfere and force me to spend my resources on something else.[25]

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[23] If we consider property rights negative rights, it means that property owners have a right to be "left alone" to do as they please with their properties, so long as their actions do not harm the similar rights of others. As we shall see shortly, if we have a negative right to property, it may preclude the possibility of welfare rights, since the latter justifies or even requires restriction of the former.

[24] However, as we shall see in subsequent chapters, it is unclear if saying that a right to be free is the most "basic" right also imply that it is an absolute right that permits no exception or limitation.

[25] As we shall see in the next chapter, Nozick's entitlement theory echoes this point.

If we are all equally entitled to be free from interference by others, welfare rights theorists bear the burden of explaining why it is justified for people or the state to interfere with other's freedom by coercing them to contribute to help others with their pursuits. For example, they may have to show why people's right to use and control their resources is not unlimited or absolute.

Some philosophers argue that we can understand why limiting property rights is legitimate if we rethink the contrast between negative and positive rights. They argue that the dichotomy between negative and positive rights is mistaken, since a right to liberty or to be free may in fact *require* some form of interference from others (Shue, 1980; Copp, 1992; 1998). [26] For example, some argue that to be fully free in the sense that one can live an autonomous life, one's basic needs must be met (Shue, 1980; Copp, 1992; 1998). Since minimal economic security and basic well-being are some of the conditions necessary for one to succeed in one's endeavours, whatever these endeavours may be, some argue that respect for freedom and autonomy requires not only that people's well-being and economic security not be removed or interfered with by others. It also requires that people be enabled to preserve and promote their autonomy (Copp, 1998), or that those goods necessary for well being be provided for the most deprived members of society (Gewirth, 1996). Human beings need certain conditions in order to act (Gewirth, 1996). If their needs are not satisfied, just being left alone cannot ensure that they can pursue their life plans that are consistent with their talents and skills. In this way, concern for human beings requires that the "proximate necessary conditions of their action and generally successful action be protected" (Gewirth, 1996, 16). In other words, adequate respect for liberty rights may not preclude but *demand* recognition of minimal economic welfare rights, such as a right to have one's basic needs met. Consequently, if health care could be considered a basic need that has to be met in order for anyone to carry out his or her life plans, then we cannot simply refrain from interfering in people's purchasing health care. Rather, we would have to actively provide a decent range of health-care services for those who cannot obtain them on their own.

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[26] There are two different ways that negative rights may require state intervention. First, to establish an institution to protect negative rights is a form of state intervention. Second, respect for negative rights, i.e., freedom, may require that the state provide the conditions (e.g., minimal subsistence) that are necessary for people to be free in any meaningful sense. Many accept the legitimacy of the first kind of intervention but reject the second kind.

Needs

We may start to see how the concept of welfare rights operates. Welfare rights are often grounded on the assumption that there are fundamental human needs that are so important that the satisfaction of them is both prudentially and morally obligatory. Many have argued that needs are objective and shared by all. Mallman (1980), for example, defines a need as a "generic requirement that all human beings have in order not to be ill, by the mere fact of being members of the human species" (p. 37). Braybrooke (1987) and Ramsay (1992) also believe that there are needs that are possessed by every human being and are necessary irrespective of any particular aim each individual may have. These basic needs often have strong moral force partly because they are shared by all human beings regardless of their specific background conditions. As Copp (1998) says, "basic needs are the things that, at some time in the course of life, are indispensable in some form and quantity to a rational and autonomous life for a human" (p. 125). Following Wiggins (1991), Copp (1998) argues that given the laws of nature and facts about the environment and human constitution, satisfaction of basic needs is necessary to acquiring and preserving one's rational agency (p. 125). The objective nature of basic needs implies that these needs are not dependent on or restricted to any subjective or particular ends (Ramsay, 1992). In fact, basic needs can be understood as the objective *preconditions* or necessary instruments for the attainment of any and all particular ends which anyone might want to pursue (Ramsay, 1992). They have to be satisfied before individuals can effectively participate in their chosen form of life or achieve any other valued goals (Doyal and Gough 1991, 54). As Doyal (1998) says, basic needs are the "universalizable preconditions that enable nonimpaired participation both in the form of life in which individuals find themselves and in any other form of life than they might subsequently choose if they get the chance" (p. 158). For example, things such as food and health care can be considered universal basic needs that are essential to maintain or restore people's ability to live, function, and flourish.

The idea that meeting basic needs is essential for all human beings is also closely related to the idea of avoiding harm.[27] As one philosopher argues, a basic need is one "in whose absence a person would be harmed in some crucial and fundamental way, such as suffering injury, malnutrition, illness, madness, or premature death" (Feinberg, 1973, 111). When basic needs are unmet, one's interests in life, health, and liberty may all be endangered. In other words, anyone whose basic needs are unmet will suffer great harm of some specified and objective kind (Doyal, 1998).

Certainly, if people are capable of meeting their own needs, then the fact that the fulfilment of needs is closely tied to avoidance of severe harm may not be morally significant. However, sometimes individuals are simply unable to meet various fundamental needs on their own. Very often one finds that uncontrollable factors such as inadequate supplies or purchasing power make it impossible for one to obtain basic needs without help from others (Nickel, 1987, 160-164).[28] The inability to fulfil one's own basic needs may subject one to severe harm or at least put one in a vulnerable position.

Many who hold the theory of objective needs and the conceptual link between needs and harm argue that individuals have a right to have their needs met. To ensure that people are not harmed, the society should ensure that everyone's needs are satisfied. If some people cannot meet these needs on their own, others have an obligation to help them. Some argue that rights claims based on human needs are like "the natural seed from which rights grow" (Feinberg, 1973, 67). They believe that when needs of great importance are at stake, people have a moral claim on others to refrain from depriving them of these goods and perhaps also to render help when any are unable to obtain the goods by their own efforts.[29] This can take different forms. For example, some argue that everyone has a conditional right to be enabled to meet their basic needs, so long as the society is wealthy enough to do so (Copp, 1992; 1998). Copp argues that this right to be *enabled* to meet one's basic needs is different from a right to be *provided* with what one needs. The former does not entitle people to call on the state to directly provide them what they need. Rather, it entitles people to call on the state to provide the *conditions* that make it possible for them to meet their basic needs, so long as the society can afford to do so.[30] This right is not against any particular person, but can be considered as one against those in the general communities or the state to a fair share of the community's scarce resources (Fried, 1978, 110; Copp, 1992, 233).[31] After all, as some argue, one proper function of the state is to protect its citizens (Jones, 1983, 285).[32]

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[27] I shall argue in the next chapter that the prevention-of-harm principle does not necessarily imply a *right* to health care.

[28] I shall discuss in a later chapter whether the 'controllability' of such factors has any moral relevance in the discussion of whether people have a claim to necessary resources.

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[29] Gewirth (1996), for example, argues that all human beings are entitled to basic goods that are the necessary conditions of action and successful action in general, since without these conditions people simply cannot act at all and thus will have difficulty meeting their life goals.

[30] However, I am not sure that the distinction between providing the conditions that enable people to meet their basic needs and directly providing what people need is as clear as Copp (1992) believes. We can imagine that in some situations the only way that a person can meet her basic needs is if she is being provided with what she needs. For example, a person who is quadriplegic and severely mentally handicapped may require others to directly provide him with his needs. They may have to feed him, give him medicine, and so on. Here, it is unclear how we can "enable" him to meet his basic needs without directly giving him what he needs.

[31] One of the questions that may arise is how we may define the "society" that ought to meet people's needs. For example, who has the obligation to help those starving in third-world countries? If these countries do not have the necessary resources to meet the citizens' need for food, does it mean that these people do not have the right to have their need met? Or does it mean that *other* countries are also part of the "global society" and thus have to help those who live in these poor countries? While I agree that this is an important question that faces philosophers who argue for *societal* obligation to fulfil people's basic needs, it is beyond the scope of this chapter to discuss the issue of international aid.

[32] As we shall see in the next chapter, libertarians challenge the assumption that the one of the government's legitimate roles is to positively promote the welfare of its citizens, since that often involves violation of individuals' property rights.

The question is, how do we go from the claim that certain needs are essential for human survival and flourishing to the conclusion that it is a matter of justice that these needs ought to be met by the *society*?[33] Or put in a different way, how do we arrive at the conclusion that one has a *right* to have these needs met by others? For example, some may argue that helping the vulnerable to fulfil their needs is perhaps an imperative of beneficence or charity, not a matter of human rights.

Many philosophers who argue that people have a right to have their needs met hold an egalitarian position. Kai Nielsen (1984), as we have seen, adopts a rights-based ethic. He argues that human beings' needs cannot be ignored by their society. Human beings have an equal right to respect and that this right demands that their needs are not ignored. Under this egalitarian account, "there must be an equal concern on the part of society for the satisfaction of the needs of all human beings" (Nielsen, 1984, 9). Provided that a society is wealthy enough to meet its citizens' needs, it is obligated to help those who are unable to do meet their needs on their own. As Nielsen says, justice should be understood as "a structuring of the institutions of society so that each person can, to the fullest extent compatible with all other people doing likewise, satisfy her/his genuine needs" (Nielsen, 1984, 47).

Nielsen (1984) believes that it is important for the society to fulfil people's needs partly because when some people have unfulfilled needs, they may be exploited by those who are in more advantaged positions. As we saw earlier, a right-based ethic is attractive partly because it ensures that people's self-respect is upheld. He worries that inequality of condition may lead to some gaining control over others, thus limiting the autonomy and undermining the self-respect of those in poor conditions. His radically egalitarian position says that, where there is an abundance of resources, people have "an equal right to the resources necessary to satisfy their needs in a way that is compatible with others likewise satisfying their needs" (p. 55). While people may not exercise this equal right to resources,

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[33] By saying that one's welfare right implies that the society has a duty to fulfil one's basic needs, it seems that welfare right can be understood as an in rem right. I shall return to this idea in the next chapter.

Nielsen contends that each person has "an equal right to as much of [resources] as anyone else" (p. 55).

While radical egalitarianism is attractive because it appeals to a non-elitist notion of human rights that accords everyone the same moral worth, it seems that radical equality can only be achieved by severely restricting or even violating some people's rights. One of the examples that Nielsen (1984) uses to illustrate his egalitarian position is that of blood transfusion. In a provocative passage he says that if one needs a blood transfusion, one has, *ceteris paribus*, "a right to an equal share or indeed to any blood plasma" (p. 55). While Nielsen does not discuss whether this right permits mandating blood-giving but only talks about the patients' right to an equal share of the "common stock," it is unclear whether the common stock only includes the donated blood or even blood in people's bodies. Suppose one needs a blood transfusion to survive, and others in the community can give some of their blood without harming themselves. It seems that a *right* to an equal share of the available stock may demand that the healthiest people who have the same blood types as these patients must give them their blood.[34] However, most people would think that this is a blatant violation of people's right to have full control over their own bodies.

Given the worrisome implications of radical egalitarianism, it is unclear that this theory can provide a convincing case for a right to health care. However, the problems of this position should not deter us from considering the possibility that other egalitarian theories may support the idea that we have a right to health care.

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[34] One may argue that Nielsen (1984) can avoid this problem if he sets a limit to what people can do to others in the name of equality. While this is a plausible move for non-radical egalitarians, it seems that Nielsen can only do so if he changes the context for his radical-egalitarian argument. For example, he may have to explain which resources people have a right to. Do they have a right only to economic resources but not body parts or blood?

A Rawlsian Right to Health Care?

Although Rawls has never argued for a right to health care, others have used his idea of fair institutions to argue that it may be a matter of rights that people's unfulfilled needs should be met by societal effort.

Rawls asks whether there are social principles all rational agents can agree upon, regardless of their specific identities. He invites us to imagine a hypothetical situation, the original position, in which all the parties are behind a veil of ignorance that prevents them from knowing whether they may occupy a favoured or unfavoured position in society. Rawls argues that the lack of information about the future will lead the parties to choose the "maximin solution." In other words, people will 'play safe' and choose social principles that will guarantee a satisfactory minimum (Rawls, 1971, 150-161).[35] To ensure that one's position is still acceptable even if one ends up being in the least advantaged position, Rawls argues that the parties will choose principles that will protect the long-term prospects of the least advantaged.[36]

Whether one's long-term prospects can be satisfied depends on the combination of primary goods one has. Primary goods, according to Rawls (1971), are things "every rational man is presumed to want" regardless of his specific plans of life (p. 62). With more of these goods people can generally expect greater chance of success in carrying out their goals, such that people would (generally) prefer more rather than less primary goods. Primary goods can be divided into two categories. Examples of primary goods "at the disposition of society," i.e., primary social goods, are "rights and liberties, powers and opportunities, income and wealth." (p. 62). The chief primary natural goods include "health and vigor, intelligence and imagination." (p. 62). As "natural" goods, Rawls claims that they are not directly under the control of the basic structure of the society, although their possession is influenced by it (p.

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[35] What is implied in Rawls' (1971) discussion of the maximin is that people are risk averse. I shall return to this notion in chapter 4.

[36] In chapter 4, I shall discuss how the concept of maximin may play a role in reflective citizens' decision of implementing a particular health-care system.

62).[37] While Rawls does not directly talk about basic needs, it seems that these primary goods are perhaps the means to satisfy basic needs.[38] Although these goods are independent of other goals, they are the necessary means for all human beings to achieve any other particular ends. Without a sufficient level of these goods, individuals may be harmed and cannot carry out their life plans.

Given that some people are in more favoured positions, they can perhaps enjoy more primary goods than those who are in less favoured positions. Granting that these primary goods are the necessary means for any endeavour, those with more primary goods will also have greater opportunity ranges than those in worse situations in the sense that the former will have a better chance of succeeding in carrying out their life plans. Rawls (1971) asks what combination of primary goods it would be rational for all to prefer when they are behind the veil of ignorance, not knowing their positions in society or their conceptions of the good. He believes that rational prudence will lead the parties to once again choose the maximin solution. They will make sure that they have a satisfactory minimum level of primary goods just in case they turn out to be in a disadvantaged group.

Rawls believes that it is not only a matter of human psychology or rational prudence but a matter of justice that the distribution of primary goods be dealt with in such a way that it benefits the least advantaged. While there is a natural inclination to think that those better situated have a claim to their better advantages, Rawls (1971) argues that these people do not deserve their fortune. After all, one's economic and social positions largely depend on one's share of primary goods, which is often beyond one's control. One is simply born with greater natural endowment or the superior character that makes one's development possible. Such advantage is thus arbitrary from the moral point of view. No one deserves to have greater natural capacities or a more favourable starting place in society; thus no one is entitled to the advantages that result. Neither does one deserve various disadvantages that result from uncontrollable factors. The problem is that those who happen to be in inferior starting positions may not have a fair chance to lead their chosen forms of life, since they lack the primary goods that are essential for them to carry out their life plans. From this Rawls argues that the equality of opportunity principle demands that society must redress the bias of contingencies by giving more attention to those with fewer native assets and others born into the less favourable social positions.[39] One way that this can be done is to improve the long-term expectation of the least advantaged. Those who have been favoured by nature may justifiably gain from their good fortune only if that can improve the situation of those who have lost out in the natural lottery. While Rawls does not directly argue for welfare rights, one can derive from this argument that the right to equal opportunity implies that the least advantaged may have a moral right to an affirmative contribution against those who are well off.

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[37] As we shall see in the next chapter, social constructionists may be suspicious of the distinction between social and natural primary goods. They may argue that the so-called "primary *natural* goods" are not "natural" or inevitable at all. Not only are they influenced by the social structure, they are in fact also at the disposition of society. For example, it seems that what count as intelligence and health depend largely on the social understanding of these concepts.

[38] James Sterba (1988), for example, says that "it is to satisfy basic needs that primary goods are typically sought" (p. 46). David Copp (1996), who argues for a similar point, believes that Rawls' primary goods are the things that people may require in order to meet their basic needs. However, while income and wealth may be considered means to satisfy basic needs, it seems that health is itself a basic need.

As I mentioned, Rawls never argues directly for a right to health care. However, other philosophers have applied his theory of justice to the issue of health-care resource allocation.[40] It seems that whether the Rawlsian framework legitimates redistribution of resources to provide health care for all depends on the importance of such care and its effect on people's ability to live an autonomous life. One may argue that health-care needs do have strong moral force partly because they are essential to people's ability to live, function, and flourish. In fact, Rawls himself acknowledges the importance of health, calling it one of the primary natural goods. As a necessary means for achieving any system of ends, the parties in the original position would all want to make sure that they can achieve at least a satisfactory level of health. If a person lacks an adequate level of health, the quality of this person's life or well-being will continue to deteriorate. Since health status is often beyond one's control and can have significant implications on people's ability to achieve their life goals, the rational agents behind the veil of ignorance would interpret the principle of justice as one that can ensure that there is *health care* available to help maintain and restore people's health to a satisfactory level.

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[39] The equality of opportunity principle says that "those who are at the same level of talent and ability, and have the same willingness to use them, should have the same prospects of success regardless of their initial place in the social system, that is, irrespective of the income class into which they are born" (Rawls, 1971, 73).

[40] In a later work, Rawls (1993) makes very brief comments on how the liberal state ought to consider "the variations that put some citizens below the line as a result of illness and accident" (p. 184). He contends that the government should try "to restore people by health care so that once again they are fully cooperating members of society" (Rawls, 1993, 184.). In that paper he refers his readers to Daniels' works, implying that he thinks Daniels' arguments of how a just society should deal with the issue of health care is consistent with his design for social structure.

Two Rawlsians have attempted to argue for a right to health care. Ronald Green (1976, 1983), for example, asks whether rational agents would consider health services as a primary good, i.e., a good that all rational agents would want, regardless of their other private goals and wants (Green, 1976). While Rawls (1971) talks about health as a primary natural good, Green contends that we need to deal with health *care* as one of the most important *social* primary goods (Green, 1976). Although Green does not call *health* a social primary good, he seems to realize how health care is at the disposition of or under the control of the society. Green argues that social decisions concerning medical care have a vital impact on everyone's health such that health-care allocation policies have to be sensitive to the issue of how disease and ill health can significantly interfere with our well-being and security (Green, 1976). We can imagine that rational agents would give health care a very important place in their prudential deliberations for the choice of a distributive principle. In fact, they would believe that securing health care is more important than income and almost as important as the basic civil liberties (Green, 1976). Green (1983) argues that health care is so important that the contract parties would not even trade equal access to health care for greater amounts of income or other social goods. He argues that health care is best handled by treating it on a par with the basic civil liberties. To ensure that other arbitrary factors such as income level will not hinder access to health care for themselves and their loved ones, the parties in the original position will opt for a principle that guarantees an equal right to the most extensive health services the society allows (Green, 1976; 1983). Access to the highest quality health services may be limited "only when that is necessary to promote the extension and enhanced quality of such care" (Green, 1983, 375). By putting the right to health care on a par with the basic liberties, Green argues that "provision of health care and health-related services comes before considerations of economic growth in the establishment of social priorities" (Green, 1983, 375).

Norman Daniels (1983; 1985), who also appeals to the Rawlsian framework in arguing for a conditional right to health care, employs a different line of argument.[41] Daniels argues that health care is special because it can restore functioning that is species-typical and essential for an individual's attainment of normal opportunity range.[42] As he says, health care "has normal functioning as its goal; therefore it concentrates on a specific class of obvious disadvantages and tries to eliminate them" (Daniels, 1983, 26).[43] He argues that "an account of the species-typical functions that permit us to pursue biological goals as social animals" can help us to understand the importance of health care and give us guidance on how we should design health-care institutions (Daniels, 1983, 12). Daniels argues that such an account of normal species functioning, together with other key features of the society,[44] can help us to determine the normal opportunity range for people in a given society (Daniels, 1985,16-7). This range "for a given society will be the array of 'life plans' reasonable people in it are likely to construct for themselves" (Daniels, 1985, 16).

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[41] While Daniels (1985) agrees with Green (1976, 1983) that health care is very important and that we should include health-care institutions among the background institutions involved in providing for fair equality of opportunity, he does not want to call it a primary social good. He says that "if we treat health care services as a specially important primary social good, we abandon the useful generality of the notion of a primary social good. Moreover, we risk generating a long list of such goods, one to meet each important need" (Daniels, 1983, 23-4).

[42] The normal opportunity range, according to Daniels (1985), is society relative. It denotes "the array of life plans reasonable persons in it are likely to construct for themselves" (p. 33).

[43] Daniels (2000) repeats the same point in a recent work. As he says, the central moral importance ... of treating disease and disability with effective healthcare services derives from the way in which protecting normal functioning contributes to protecting opportunity" (p. 315).

Realizing that the normal range of opportunities open to people is itself socially relative and depends on various technological and cultural factors, Daniels believes that it may be necessary for the society to rectify the impact its structure has on people's range of opportunities. He thus extends the equality-of-opportunity principle to health care to justify correction for natural and socially induced disadvantages (Daniels, 2000).[45]

Daniels (1985) believes that the effect of illnesses and injuries on people's opportunity ranges is a matter of justice that needs to be dealt with on an institutional level. He reminds us that illnesses and injuries are often not under the individual's control and thus arbitrary from the moral point of view.[46] Just as people are born into various social and economic conditions, they are also born with different physical and mental vulnerabilities. While some people are born healthy, others are born with various genetic problems. The concern is that their initial health status and their economic or social conditions can influence their health status and opportunity ranges later on in life. For example, a person who has severe respiratory problems and is poor may not be able to afford various health-care services to treat his conditions, so his health problems may persist throughout his life. What makes health problems an issue of justice or rights is that these undeserved disadvantages may create profoundly significant obstacles for people who live with such health problems. Various illnesses and injuries can take away people's capacity to function properly or pursue their life plans that could reasonably be adopted in their society. For example, if he is not properly treated, the patient with severe respiratory problems may not be able to pursue an education or participate politically. He is thus unfairly deprived of his opportunity to use his capacities to participate as a fully functioning citizen. Daniels adopts Rawls' fair-opportunity principle and argues that health-care institutions should be included among the background institutions involved in providing for fair equality of opportunity (Daniels, 1983; 1985). He argues that health-care resources should be distributed in such a way that they provide access to health-care services for those individuals who suffer from various diseases and injuries that may hinder their fair chance of equal opportunity.[47] While Rawls does not use the rights language and only talks about a duty of justice, Daniels argues that the equality of opportunity principle accords all citizens a right to a fair allocation of health-care resources.[48]

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[44] Some of the features of the society that determine the normal opportunity range for such society include "its stage of historical development, its level of material wealth and technological development, and -- even more important -- cultural facts about it" (Daniels, 1983, 16).

[45] Although Daniels (1985) recognizes the fact that the effects of some impairments are socially induced, he still thinks that they are distinguishable from those effects that are "natural." However, as we shall see in the next chapter, social constructionists may deny that there are any effects that are purely "natural."

[46] As we shall see in chapters two and five, the possibility that one's illness or injury is self-caused raises the question of whether this alleged right to health care as proposed by some liberals only applies to treating those health conditions that arise *beyond the patient's control*.

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[47] However, it is unclear whether Daniels' (1985, 2000) notion of opportunity range is the same with that of Rawls' (1971). Rawls' discussion of equality of opportunity focuses on guaranteeing everyone the chance to gain access to public offices and positions as well as minimizing the disparity between various classes in both means of life and the rights and privileges of organizational authority. However, Daniels' notion of equal opportunity may be broader, since "the array of life plans that are reasonable to pursue given various conditions of the society" seems to include more than public offices and positions. Nonetheless, in a recent article, Daniels (2000) does seem to think that one's fair opportunity range is defined by reference to the individual's talents and skill. Perhaps the "array of life plans" Daniels has in mind is also restricted to employment and political opportunities.

[48] However, Daniels (2000) does not think that people have a universal right to *all* kinds of health care. He wants to restrict this right only to health-care services that are necessary to restore functioning. As he says, "By keeping people functioning as close to normal as possible, within resource limits, we discharge part of our obligation to protect fair equality of opportunity" (p. 315).

Recall that rights are binding on those who bear the duty to fulfil such rights. In other words, those who are entitled to various welfare rights have a legitimate claim on others. Like many others who argue for a right to health care, both Daniels and Green believe that the right to health care should be backed by legal enforcement. These writers are not just saying that one can rightly *expect* others to contribute to our welfare. They are also not simply claiming that people should from their own conscience realize that they ought to contribute and help the needy get access to health care. Contribution to publicly-funded health care is not simply a matter of beneficence or kindness. Rather, both Green (1976, 1983) and Daniels (1983, 1985) argue that this obligation to provide health care should not depend on individuals' conscience or their willingness to fulfil their obligation but should be enforceable by various institutions. They argue that such a right provides the moral basis for criticizing societies that do not provide universal access to various health-care services. To ensure that the social institutions can protect people's right to equal opportunity, both Green (1976, 1983) and Daniels (1983, 1985) believe that it is justified or perhaps even required for the state to redistribute resources to provide health care to all. This notion of health-care right tells us what is mandatory, not optional, on the part of others. The appeal is not to benevolence and charity; rather, it involves ideals such as justice and equality. Not providing patients with health-care services is not only deeply immoral on an individual level; it is in fact unjust on an institutional level. The stringency of justice explains why the state can use coercive power to ensure contribution to provide universal health care.

It is not difficult to understand why people in modern liberal societies want to hang on to the slogan of "right to health care." The idea of a welfare right to health care does seem to fit well with the liberal egalitarian idea of minimizing undeserved disadvantages. In developed countries, resources are often distributed unequally. While some people can afford various luxuries, others cannot even meet their basic needs. When the economic situation in a developed society is favourable, it seems that there are good reasons to argue for some kind of social programs to help those who are in dire needs. However, not everyone is convinced that the goals of helping those in poor conditions and minimizing undeserved disadvantages imply that people have a positive welfare right to health care. It is to the criticisms of the welfare-right theory that I shall turn in the next chapter.

CHAPTER TWO

PROBLEMS OF "NEEDS" AND "RIGHTS TO HEALTH CARE"

Although the notion of health-care rights is widely used in political debates, some have argued that we do not possess such rights. Libertarians, for example, in general deny that such rights are human rights. As Engelhardt (1996) says, a right to health care and other welfare rights are all wrongly created.

There are two main reasons why libertarians vehemently argue against an extensive welfare state. First, they question the validity of the notion of objective human needs. Second, they believe that respect for people's liberty prohibits coercive redistribution of resources. I shall discuss libertarians' second objection later in the chapter. I want to first deal with the issue of needs as discussed by libertarians.

As we saw in the last chapter, many rights theorists base their argument for a welfare state on the concept of human needs, which are often assumed to be objective and shared by all human beings. They argue that, when their objective needs are not met, human beings suffer great harm and are unable to lead autonomous lives (Doyal and Gough, 1991; Copp, 1992; 1998). For example, if people's basic health-care needs are not fulfilled, they may suffer from severe disabilities, excruciating pain, or even die prematurely. Thus, they may be prevented from living as fully functioning citizens. As we saw in the last chapter, Norman Daniels (1985) is concerned with how various illnesses and injuries may affect people's opportunity to participate as fully functioning citizens. He and other welfare-rights theorists believe that the grave effect of unfulfilled needs on people's well being and autonomy supports their argument that people have a moral claim on others to render help when they are incapable of meeting these needs on their own.

However, not everyone is convinced that the theory of human needs has any prescriptive force. Some philosophers argue against the idea that people or the state can legitimately coerce redistribution of resources to finance various welfare programs such as universal health care to meet people's needs. In fact, some are skeptical that we can even have a theory of human needs. In this chapter, I shall discuss two distinct problems with the theory of human needs. First, there is the issue of whether needs are in fact objective and universal. Second, there is the question of whether any alleged human needs imply welfare rights in the sense that people are entitled to be helped by others in pursuit of their own welfare. In what follows, I shall discuss these issues as understood by social constructionists and libertarians.

Libertarians' Objections to the Theory of Needs

One of the most controversial aspects of a theory of human needs is whether needs are in fact objective and universal, as claimed by those who argue for welfare rights. Contrary to welfare-rights theorists or "objectivists" about needs, libertarians in general do not believe that we can come up with a canonical agreement in secular moral reflection about what counts as human needs. There are numerous views of what justice requires, and the limits of reason makes it impossible for us to determine which view should be adopted. As Engelhardt (1996) says, if "there is no satisfactory secular access to that singular viewpoint, then it will not be clear in general secular terms whether such a viewpoint exists" (pp. 36-37). He argues that attempts to justify a content-full secular ethics are doomed to fail.

Applying his skepticism to the possibility of coming up with a canonical agreement on needs, Engelhardt (1996) reminds us that people's opinions of what constitutes needs differ. This is partly because people in a pluralist state come from different economic and social backgrounds and may have different values and moral visions. These differences often take people in different directions when individuals think about needs and how they may be harmed if these needs are not fulfilled. Moreover, people have different life goals and therefore what they will need to achieve such goals also differ. It is sometimes argued that needs are conditional or goal-relative. Need statements are only intelligible against a background of certain assumed ends or goals. As Engelhardt argues, whether something is categorized as a need or a preference depends on the particular view of the good life one subjectively endorses. Since people have different life goals and moral visions, their 'needs' and their conceptions of these 'needs' inevitably vary. For example, while a farmer may 'need' a barn to raise his animals, a concert pianist may 'need' a grand piano on which to practise. Their needs are conditional on their life goals, and people who do not share the same goals inevitably have different needs.

In other words, there simply does not seem to be an objective or goal-independent way to talk about needs. This motivates some libertarians to get rid altogether of the needs language that is often used as a rhetorical device in supporting universal health care and other welfare programs. Engelhardt (1996), for example, argues that there are no significant differences between needs and preferences. Needs, according to him, are inherently subjective. Like preferences, they differ among individuals who hold different life goals or moral visions.

In response to this charge that what one needs depends on one's subjective life plan, welfare theorists have to explain how they can justify the claim of welfare right. If we do not all share the same needs, this can be a serious problem. After all, a theory of objective needs seems to be a necessary condition, although not a sufficient condition, for supporting welfare rights. In other words, variation among people may imply that we lack the necessary condition for supporting welfare rights and so various social programs that are based on a mistaken notion of objective needs and values are illegitimate. Libertarians worry that social policies that are grounded on such a contentious notion of needs may be simply results in the dominant class protecting its own goals and "needs" and downgrading those of the minority as false or inferior.[49] For example, they worry that attempts to determine one "universal" standard of needs will result in some population groups forcing other groups to assimilate their goals.

In other words, it is unclear how a democratic government can legitimately claim that individuals have a *positive welfare right* to have their subjective interests met by moral strangers.[50] If there is no agreed objective or determinate way to evaluate various interests or concepts of the good, then a state that values democracy ought not arbitrarily decide for its citizens what conceptions of the good life should be endorsed. As we saw in the last chapter, if autonomous agents have any rights, they have liberty or negative rights and in general should not be interfered with in their endeavours. They are the owners of their lives and should be allowed to pursue their self-chosen life plans, so long as they do not harm others or infringe on the autonomy of other human beings (Hospers, 1992).[51] It follows that if these autonomous individuals do not share the same life plans and have not given their consent to contribute to help others fulfil their subjective life goals, a liberal state cannot legitimately prioritize others' 'needs' over their own and coerce redistribution to fund the prioritized 'needs.' As we shall see later in this chapter, libertarians argue that coercive redistribution to finance certain 'needs' such as basic health care is equivalent to forcing some individuals to work for others' preferences. Such a coercive mechanism allegedly fails to respect people's liberty rights; it violates the principle of autonomy and self-ownership.[52] It conflicts with the decisions of individuals who may not wish to participate in realizing a particular system of health care and is thus unjustifiable (Engelhardt, 1996).

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[49] As we shall see later in the chapter, social constructionists also share some of the same concerns, although they do not accept the libertarian conclusion.

[50] I shall challenge the argument that there are no objective needs but only subjective interests and preferences later in this chapter.

What About Social Constructionism?

Libertarians are not alone in being suspicious of the theory of objective human needs. Social constructionists are also reluctant to treat various needs claims as something universal and objective. Hacking (1999) defines social constructionism as the ideology that various concepts that are said to be objectively discovered in the natural world, holding independently of society, are in fact social constructs.[53] When one says that X is a social construct, one holds the idea that "X need not have existed, or need not be all as it is. X, or X as it is at present, is not determined by the nature of things; it is not inevitable" (p. 6). The ideas of race, gender, and needs are brought into existence or shaped by social events, forces, and history. Given that these components can change, so can the present state of things. In other words, the present state of things is contingent and not inevitable. Welfare programs that are founded on the assumption that certain needs are inevitable and objective among human beings are therefore flawed.

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[51] Libertarians argue that if others have harmed you, they have an obligation to rectify the past injustice, regardless of whether they want to compensate you or not. Although libertarians believe that it is a matter of justice that such people have to help the disadvantaged, they do not think this is a matter of welfare right.

[52] Hospers (1992), who is also a libertarian, argues that taking money from another person forcibly to pay for one's "pet projects" is the same as compelling them to cooperate, i.e., "enslave them" (p. 42). He does not think taking money to help others justifies coercive redistribution. He compares that to a robbery. As he says, "[t]he theft of your money by a robber is not justified by the fact that he used it to help his injured mother" (p. 42).

It is important that we do not understand social constructionists as arguing for social relativism. What makes something a social construct is not simply that such a thing is the contingent upshot of societal conditions (Hacking, 1999, 12). Certainly, the ideas of gender and race are results of historical ideas and social processes. However, that is only part of the picture. What makes these ideas social constructs is mainly how people uncritically take these concepts for granted or as inevitable. The ideas of race and gender, for example, are often confused with biological and natural categories, and claims about them are confusedly justified by natural science. Moreover, various social constructs often have a negative connotation. When someone claims that a certain idea such as race is a social construct, she is probably not only criticizing the uncritical acceptance of such contestable notion as if it is absolute.[54] She may also be saying that such a notion "is quite bad as it is" and that people who are being labelled by such notions may be better off if such concept is radically transformed or abolished (Hacking, 1999, 6-7).[55] Her claim that the notion is a social construct can be taken as partly a political or social strategy of trying to bring attention to how such uncritically accepted notions are disadvantaging certain population groups.

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[53] Hacking (1999) is not using the term natural world in a theological way. This term depicts the world that is not controlled by social laws but perhaps scientific or physical laws (e.g., law of gravity).

[54] Hacking (1999) points out that it is not a necessary condition for people who realize that something is a social construct to say that it is also a bad thing. However, most people who discuss social construction "want to criticize, change, or destroy some X that they dislike in the established order of things" (p. 7).

One of the writers who reminds us how the notion of gender is constructed is Naomi Scheman (1993). While the differences between the sexes often give a feeling of essentiality about them, Scheman cautions us that gendered attributes and relations are in fact contingent. When they are used among us as inevitable facts, they often have discriminatory or degrading effect on women. Scheman invites us to rethink about the idea that women are essentially, i.e., of their very nature, subject to male domination. She points out that such a concept is often taken to be some objective and simple "fact" or "truth" discovered in the world, when in fact this value-laden characterization is a mistaken conception about the females. Such a concept perpetuates the bias towards women and therefore ought to be changed or abolished.

What Scheman (1993) is mostly concerned about is *who* exactly "discovers" such "objective facts and truth" about women's needs and acts on such "discoveries." She reminds us that "the objects of knowledge" are not value free, but are often shaped by the forces of race, class, gender, and other system of domination and privilege (Scheman, 1993, 211). She cautions that we should be suspicious when "knowledge" is taken as a definite fact or a set of facts. She reminds us that claims about women's needs are not simply objective and "bare truth unadorned by interpretation" but rather constructed by those who are in positions of privilege (Scheman, 205; 211-2). This can be problematic, since these privileged people who allegedly discover knowledge about women and the world may have the power to distort views of various social relations and create a political climate that perpetuates such mistaken views.

In other words, Scheman (1993) shares the libertarian concern that we ought to be careful about the notion of "objective needs," and how issues of social welfare are often grounded on such value-laden ideas. However, Scheman differs from libertarians in some other ways. While libertarians deny the validity of needs talk and the legitimacy of tax-funded welfare programs to fulfil such needs, Scheman does not think that we have to abandon the needs language. She also does not think that welfare programs are illegitimate. Rather, she is concerned with who gets to interpret women's needs and establish welfare programs on such interpretation.

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[55] I shall examine the implication of this argument on the identification of population groups in chapter four.

While Scheman does not explain in detail the problems of many existing welfare programs, another philosopher who holds similar views provides a detailed account of these problems. Like Scheman, Nancy Fraser (1989) also wants to keep the needs language. She believes that women do have needs and that welfare programs should be in place to ensure that such needs are met. However, she is cautious about who interprets such needs. She points out that in dealing with issues around social welfare, interpretation of people's needs is itself a political stake. Like Scheman, Fraser reminds us of the question of *whose* interpretation of women's needs we are dealing with, and why such interpretation should be authoritative. She points out that women do have real needs that are not mere preferences. She also claims that these needs ought to be met by various welfare programs. However, she is concerned with who should authoritatively decide what various groups of women really need and how these needs should be met. While women are the principal clients and beneficiaries of the social-welfare system, she reminds us that the current system in the United States does not deal with women on women's terms. Rather, it positions women as mere passive and submissive subjects.[56] Most often women of various groups have little or no say in how their needs should be interpreted and fulfilled. The problem, Fraser points out, is that the state somehow pre-empts the power to define women's needs. Officials rely on the "natural" and "traditional" interpretations of women's roles and interpret their needs accordingly. These officials often ignore the fact that these welfare recipients are rational agents who are end-seekers. Such ignorance often leads officials to take certain gender subtext for granted and simply build welfare programs on the mistaken assumption that the society is divided into two separate spheres of home and work, spheres that *belong* to women and men respectively. The system and various welfare programs that are established on these concepts therefore fail to help the recipients but rather harm their self-esteem and distort their autonomous identity by reinforcing some basic structural inequalities.

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[56] The reasons why women are the principal clients of social-welfare programs include the fact that women as a group are significantly poorer than men partly due to their unpaid domestic labour, and that they tend to live longer than men.

What is troubling and ironic about these uncritical notions of separate spheres is that statistics show that in reality less than 15% of American families conform to this model (Fraser, 1989, 149). Yet, the assumed separate spheres seem to be immune from analysis and critique. The presumed inevitability of the two separate spheres is evidence that such categorizations are social constructs that take certain contestable assumptions for granted. Officials who have no understanding of these perspectives or history simply project onto the recipients their biases and uncritical assumptions. Welfare measures to "address needs" based on such unexamined characterization of the two spheres are therefore doomed to fail.

Fraser suggests that we take a close look at the politics of needs interpretation, given that the identities and needs that the social-welfare system fashions for its recipients are interpreted ones. She points out that those who argue for objective theories of needs, such as Braybrooke (1987), take the interpretation of people's needs as simply given and unproblematic (Fraser, 1989). These theories do not question who has the knowledge and authority to interpret various people's needs, how such authority is developed, and from what perspective or with what interests in mind they interpret these needs. For example, in establishing welfare programs, very often officials do not have first-hand experiences of the issues faced by welfare recipients. Nonetheless, they are still given the authority to interpret and define the recipients' needs. The fairness and adequacy of these authorized interpretations are usually simply accepted and unquestioned.

The problem about needs interpretation is therefore partly the result of the fact that dominant groups can often articulate need interpretations in such a way to exclude counter interpretations, such as those expressed by subordinate or oppositional groups (Fraser, 1989).[57] Recall that this is a worry shared by libertarians. When the relations of dominance and subordination are supported by both domestic and official economic institutions subordinates are subject to the power asymmetry and inevitably disadvantaged systemically.

Social Construction of Disability

Similar worries about the notion of universal or objective needs are shared by Michael Oliver (1990), who is concerned about how the majority often assume that the needs of the disabled can be interpreted as simply biological issues.[58] Disability is often understood as a physical or psychological impairment that can be objectively diagnosed according to medical criteria. When officials take this meaning of disability for granted, they design health-care and welfare programs according to these uncritical notions of disability and needs. However, Oliver points out that the notion of disability cannot be understood as simply an objective idea of medical or biological problems that is independent from the direct experiences of those who live with these conditions. He argues that disability as a category can only be understood within a cultural and social framework. Various conditions or experiences faced by people who live with such conditions are perhaps more appropriately considered as social restriction than biological restriction that is objective and inevitable. We simply cannot provide an adequate theoretical and empirical account of disability cross culturally but have to understand it within a certain social setting. He reminds us that we need to be careful about who defines disability and how they define it, since such definition can significantly affect the experiences of people living with various conditions. Oliver uses the example of Groce's study (1985) of Martha's Vineyard to support his claim that disability is very much a social construct. Because of intermarriage and the presence of a dominant deafness gene, there was a relatively high proportion of deaf people on the island off New England coastline. However, the deaf people there were not socially "disabled" or excluded from society. In fact, they did not even forge their own deaf culture.[59] There were few social restrictions on deaf people, who interacted with everyone else and participated as fully functioning citizens. They lived the same way as those who were not deaf and were considered part of the community. The main reason why the deaf people on the island had the same social status and communicative ability with everyone else was that most people on the island knew sign language. In this way, the societv was "functionally bilingual" such that those who were deaf were not disabled or separated from the non-deaf (Oliver, 1990).[60]

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[57] As we shall see later, this worry is part of the reason why I argue that empowerment is an essential norm of legitimacy for any pluralistic political process.

[58] As we saw in the last chapter, Rawls (1971) calls health a primary natural good, implying that such a good is not under the control of the society. However, as we shall see shortly, it seems that effects of various health conditions and "disabilities" are often results of the social structure.

Oliver's example shows that it is not deafness itself that disables people or excludes them from participating in community lives. It is not the physical impairment by itself that makes people who live with certain conditions unable to participate as fully functioning citizens. Rather, it is a combination of the physical condition *and* the societal attitude towards such impairment that makes those who have various impairments disabled.[61] Certainly, the social constructionists' view does not deny the significance of germs, genes, and trauma and their effects on people who live with such conditions (Abberley, 1987). However, it reminds us that physical symptoms are not the only criteria in determining disability. The *effects* of such symptom cannot be understood simply as medical or biological factors, but as a complex combination of social and historical factors. The objective definition of disability, which is readily confused with biological impairment, ignores the possibility that people's experiences are determined largely by social attitudes towards such disabilities. Social policies that are based on such inadequate definition of disability are unlikely to address the concerns of those who live with various impairments. While many take for granted that individuals with similar conditions suffer similarly, some anthropologists remind us that the experiences of these individuals can vary from society to society and from age to age. In this way, we ought to be sensitive of such variations in understanding the needs of these individuals (Oliver, 1990).

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[59] As we shall see in chapter five, the varied experiences of people with certain condition makes the identification of population groups a very complex and sometimes impossible process.

[60] Another example of how disability can be understood as a social restriction is the situation of people whose physical mobility depends on wheelchairs. For these individuals, whether they are disabled or not largely depend on whether public places are equipped with ramps and elevators. Certainly, these individuals will be disabled if we only have stairs. However, that is not inevitable. Minor changes can be made to accommodate people who can and cannot walk.

[61] As we shall see in the next chapter, the fact that the society's attitude towards various impairments can prevent people who live with such conditions from participating as fully functioning citizens implies that measures to restore functioning will include more than health-care services but also education and perhaps social restructuring.

In other words, we ought to be sensitive to the social perceptions and definitions of various impairments and needs in order to understand the needs of people who live with various conditions.[62] As Susser and Watson (1971) point out, social forces can significantly influence the conceptualisation, recognition, and visibility of disorders. Given the differences in such perceptions and definitions, a condition may be seen as a disorder in one place and time, but not in another. In this way, the experiences of social restriction for many who live with certain conditions are not absolute or inevitable. Hacking (1999), for example, observes that when people are classified in certain ways and such classifications are "known by [these] people and those around them," the effect can be "interactive." These classifications can change the ways in which individuals experience themselves" and may even lead people to evolve their feelings and behaviour in part because they are so classified" (p. 104).[63]

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[62] As we shall see in the next chapter, the fact that the social structure is partly responsible for the experiences of those who live with various conditions implies that it may be a matter of justice that the society corrects the disadvantages experienced by people who live with such conditions.

[63] For example, "mentally retarded" children who are "removed from their class for more individualized tuition" know how they are classified, "they develop not only individual but collective new patterns of behaviour" (Hacking, 1999, 112).

One of the lessons we can learn from social constructionists is that the social perceptions and definitions of various conditions can have fundamental impact on how the society thinks about various health needs of individuals with such conditions, and how their needs can or should be met. Recall that Scheman (1993) and Fraser (1989) regard it as important for social-welfare programs to meet women's needs, but are worried about who has the authority to interpret these needs. Oliver (1990) also agrees that the needs of those who live with various conditions should be met by various social-welfare programs to ensure that these people's chances of living an autonomous life would not be unfairly limited. Like other social constructionists, Oliver worries about how those who have no first-hand knowledge of living with various conditions can authoritatively decide the needs of those who do live with such conditions. He worries that those officials who do not have personal experience with such conditions may not address people's needs on their terms, but rather impose an authoritarian interpretation of what they *should* need. As we shall see in later chapters, in order to ensure that welfare programs truly address the recipients' needs, potential recipients have to be allowed and encouraged to voice their concerns and help shape the programs.

An example of how third-person interpretation of what people need can be damaging to people is shown in the Oregon Plan. When the state of Oregon initially proposed its priorities for state-funded health care, services for people with disabilities were given lower priority. Apparently many respondents of a telephone survey conducted by the officials said "they would rather be dead than wheelchair bound or blind" (Young, 1997, 343). However, what is worth noting here is that many respondents were "able-bodied people asked to put themselves in the situation of a person in a wheelchair, or a blind or deaf person" (Young, 1997, 343). In other words, many respondents in fact had little first-hand experience of living with such conditions and perhaps failed to understand the lives and issues faced by people with disabilities. As Young points out, people with disabilities usually think that their lives are quite worth living.[64] What prevents them from living their lives as well as possible is not their conditions but often the discriminatory impediments. When officials and other citizens have no experience or understanding of the issues faced by people with disabilities, it is dangerous to allow them to dominate the decision process and project onto others their own fears and misunderstanding of such disabilities and establish arbitrary and possibly degrading policies. As we shall see in the next chapter, in order to reach decisions that can truly reflect the needs and concerns of those who live with various conditions or impairments, the decision-making process ought to include the voices of those who live with such conditions.

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[64] Doyal and Gough 's (1991) citation of Townsend's survey also shows how people's

Libertarians' Response

Now we are faced with the issue of whether social constructionists can consistently argue against the notion of objective needs and accept the concept of the welfare state simultaneously. If needs are not objective and uniform across the species, but depend on the unique experiences and life goals of particular individuals and groups, one may question why others have to help finance the specific projects that only benefit individuals with particular circumstances. It is apparently equivalent to asking people to redistribute their resources to fund other people's preferences. While requests for voluntary donations to help finance such projects are legitimate, it is unclear that universal coercive taxation to fund them is justifiable. If as a moral stranger I do not share the same experiences or moral visions with others, why should *I* be forced to contribute to *their* projects? Certainly, people who share their vision could voluntarily get together and all contribute to their commonly-chosen projects. However, it is questionable that we can move from this premise to the conclusion that even people who do not share their goals and interests have to redistribute their resources

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perception of others may not be accurate. In Britain, Townsend found that almost 44% of those *he* defined as severely deprived felt no deprivation themselves. Although Doyal and Gough interpret this as evidence that "subjective feeling is not a reliable determination of human need," perhaps we can think of this example as a "classic case" that shows how people may lack understanding of others' living experiences and impose their perceptions onto others.

to support such projects. In fact, as we shall see later, it seems that even if I share the same goals and interests with others, according to the libertarian doctrine I am still not obligated to help others who cannot successfully pursue the same goals on their own.

Libertarians may also be concerned with the social constructionists' view that welfare recipients themselves should determine how the programs must accommodate their self-interpreted needs. This concern may be partly due to the fact that such programs require *others* to contribute. If such individuals who do not share their goals and needs have to help pay for these programs, one may argue that they should at least have a say in deciding how the programs should be run, and whether certain programs are in fact needed.

Social Constructionists' Responses to Libertarians

It seems that social constructionists may attack the libertarian assumption that needs are like preferences that differ among individuals. So far we have been assuming that social constructionism and objectivism are incompatible. However, this assumption needs to be qualified. Social constructionism does not preclude the possibility that we share some common needs. While we may have different experiences and the means to fulfil various needs may differ among people, it seems that people all share certain basic needs, such as basic health.[65] It appears that human beings do share various characteristics. While our experiences have been differently constructed in different societies and the means that are necessary to fulfil our needs may differ among individuals, "we are none the less left with a great deal of overlap and convergence among cultures at the level of these experiences" (Nussbaum, 1995, 120).[66] For example, we are mortal beings that have bodies of a certain sort and need things that we do not control. And if we look at Rawls' (1971) idea of primary goods, it seems that rationally self-interested agents all share certain goals in the sense that they all like to have certain conditions satisfied, regardless of their particular goals.

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[65] Although Galston (1991) does not employ the needs language, he does talk about a "limited but nonetheless objective account of well-being" (p. 168). He says that we all share certain evil-aversion. For example, it seems that we all agree that "death, wanton cruelty, slavery, poverty, malnutrition, vulnerability, and humiliation are bad" (p. 168).

[66] For example, one may argue that everyone has "survival needs." However, what is necessary to fulfil such needs may differ among individuals. While a person who is diabetic may need insulin to stay alive and maintain her health, another person who is severely

However, libertarians may argue that this response is insufficient to support tax funded social-welfare programs to ensure that certain people's needs are not being ignored. Even if we assume for the sake of argument that people do share the same goals and needs, that does not imply that coercive redistribution to fulfil these needs is warranted. The assumption that people have similar needs does not explain why moral strangers who have no special relationship to each other have to help finance a welfare state to provide the needed resources for those who cannot acquire them on their own.

Social constructionists may respond to libertarians in the following way. They may point out that these so-called "moral strangers" do have an obligation to contribute and help members of certain social groups fulfil their needs. They may remind us why these people cannot fulfil their needs on their own. Given the history of various social groups and power relations between them, social constructionists may argue that the social structure and various discriminatory attitudes have made it more difficult or even impossible for certain people to fulfil their needs. The oppressive history of class relations, for example, may have systemically and constantly treated certain population groups as inferior and made it difficult for people in these population groups to fulfil their needs on their own. Various discriminatory barriers may have made it difficult or even impossible for certain people to enter educational institutions and the workforce, so that in the end they may not be able to obtain the means necessary to fulfil their needs. Social constructionists may also argue that the way that the dominant culture has been authoritatively interpreting the roles and needs of certain people and shaping their experiences has also unjustly placed these people at a disadvantage. In other words, decisions made by the dominant social groups have sometimes unintentionally and perhaps also intentionally neglected the concerns of certain vulnerable groups, such that these decisions have been responsible for oppressing or harming the

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injured may need surgeries to prevent dying prematurely.

integrity and autonomy of members of these groups. The fact that some people are now in disadvantaged positions is not inevitable or natural. We also cannot say that they are (solely) responsible for what happened to them. Rather, they are being put in that position by the dominant and oppressive culture that has imposed arbitrary or discriminatory notions of essential functions and values on them.[67] Given that these disadvantages are created and caused by the unjust social culture, the principle of rectification demands that the society provide various welfare projects to correct such injustice. How people with disability may suffer is partly an indirect result of the mistaken views about their quality of life.

An example can shed some light on this issue. Suppose a divorced single mother now needs financial help because when she was married, she stayed home to take care of her children and was never financially rewarded for her labour. Libertarians may argue that the woman's situation is not other people's fault. She herself chose to stay home, and so the fact that she was not paid for her work and that she is now economically disadvantaged is simply the result of her own choice. In this way, other moral strangers should not be forced to contribute to help her, regardless of the possibility that her and her children's well being may be compromised if their needs are not met.

However, social constructionists may remind libertarians that the woman's "choice situation" simply was misrepresented. They may argue that the individualist approach that focuses on individual choice and responsibility simply misconstrues the structure of her "choice" and the result of that "choice." For example, they may argue that the situation of this single mother is not an individual matter but more of a social problem. They may point out that this woman is in fact the victim of a patriarchal society that expects women to take on unpaid domestic labour and ignore their financial autonomy. In other words, her economic situation is not an inevitable result or the consequence of her own autonomous choice, but rather the effect of the oppressive patriarchal society and family structure. Social constructionists may therefore argue that, in order to correct the effect of such discriminatory and unfair social structure, tax-funded social-welfare programs that address women's needs on their own terms are morally required to rectify the injustice created by the dominant culture. According to this argument, demands for welfare programs are not issues of charity that give individuals freedom to decide whether they want to contribute and how they may want the program to operate. Rather, they are issues of justice that demand universal participation to rectify the discriminatory problems that have created the social restriction on some population groups. Granting that various social-welfare programs that address women's needs on their own terms are essential to prevent further oppression of these people, they are not only justified but also morally required.

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[67] For example, a person who is in wheelchair may be in dire financial condition because he is "disabled" in the sense that he cannot get into certain buildings and so has difficulty finding gainful employment. One may argue that the way that the dominant "able-bodied" culture has labelled this individual is responsible for putting the individual in a disadvantaged position.

This is an attractive response, given that libertarians themselves would agree that rectification justifies redistribution to correct past injustice. In other words, redistribution to establish welfare programs such as universal health care can be legitimate even if that requires coercion. However, libertarians may object to this argument by raising difficult questions about the proof of causal effect (i.e., how certain populations come to suffer in such a way). For example, there may be various factors that contribute to why an individual or a group of people cannot meet their needs. It may be difficult to prove that social injustice is the single or immediate cause of such disadvantages. Also, libertarians may point out that the social constructionists' argument ignores the possibility that many people are in disadvantaged positions through no fault of others. Given the problem of proving causal effect, it is at least difficult, if not impossible, to distinguish these people from those who suffer through the injustice of others.[68]

I acknowledge the complexity in proving causal effect in terms of how various individuals and social groups have been disadvantaged as a result of unfair discrimination. I admit that it may be difficult to tell how far the predicaments of the present were produced by discriminatory practices. It may also be difficult to determine who exactly benefited from such violations, and how much they have benefited. These issues may complicate the process of trying to determine who should compensate those who are now in disadvantaged positions. I also agree that there may be various factors that all contribute to why certain individuals or population groups are in disadvantaged positions. In other words, discriminatory practices may not be the only factors that put these individuals in such conditions. However, I do not see this to be a problem *only* for social constructionists who demand redistribution to correct alleged injustice. Libertarians in fact bear the same burden from the other end, if they want to deny payment for rectification. They have to prove that discrimination or other forms of unfair dealings were *not* at least one or some of the factors that have contributed to the disadvantaged conditions and experiences of members of these social groups.

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[68] And even if we can show causal effect, libertarians may only allow temporary measures that can correct past injustices and not agree to long-term or permanent redistributive programs once justice is restored.

Even if libertarians grant that compensation is necessary in cases where there is evidence of past wrongdoing, they may still argue that the principle of compensation does not extend to those people whose disadvantaged positions are not the results of others' fault. While those who have been wronged may legitimately say that they are entitled to be helped by their wrongdoers, people who are in disadvantaged positions through no fault of others may not be able to demand the same help. Libertarians may argue that even if these people are also in dire need, they do not have a welfare right, i.e., they are not *entitled* to coerce others to help them to finance the necessary means to satisfy their needs. They may argue that it is not contradictory for one to say that the society should not be required to provide such means to satisfy these needs. The assumption that people all have needs that ought to be satisfied may simply imply that the state should leave people alone and allow them to use whatever means they see fit to fulfil their needs. It does not imply that one owes others an obligation to help fulfil their needs. In other words, it seems that libertarians can still consistently argue that if others did not cause certain individuals' disadvantaged positions, these individuals should be responsible to find the best means to fulfil their own needs.

Problems of Prescriptive Needs Statements

What libertarians are trying to do is to challenge the claim that assumptions about needs have any prescriptive powers. Even if we agree that people share certain needs, that by itself does not imply the existence of welfare right such that people are entitled to be helped by others to satisfy these needs. Libertarians may point out that there is no logical or necessary connection between empirical 'needs statements' and political 'ought statements' (Fitzgerald, 1977, 208). For example, even if we accept that health care is a need shared by all human beings, it is still not self-contradictory to claim that others do not have to provide us access to various health-care services or that we do not have a claim right to tax-funded health care.[69]

What the "logical" argument shows is that agreement on factual statements is not decisive. There is still a gap between empirical evidence and normative conclusions (Fitzgerald, 1977, 206). Even if people generally agree that they share certain needs and that unfulfilled needs can constitute harm by depriving the individual of something important, there may still be profound disagreement on the significance of such harm and what, if anything, should be done about it. Agreement on the importance of certain health-care needs does not imply that people also agree that there is a *right* to have these needs fulfilled. People have different moral visions of how much should be provided, and who should provide such services. They may set different standards for health care and endorse different criteria of what constitute basic or needed health care.[70] For example, people may disagree on what impairments of normal species functioning constitute unfair disadvantages.[71] More importantly, they may disagree on what a just health-care system should look like.[72] The problem of the notion of welfare rights is that it seems to downplay the importance of such value disagreement and treat some of the values as if they are absolute or morally authoritative.

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[69] However, just because it is not self-contradictory to say that some needs ought not be met does not mean that there are no legitimate reasons for the society to fulfil such needs. After all, we do not tell people to keep promises only because it would be self-contradictory to do otherwise. There are also other moral reasons why it is important for people to keep their promises.

[70] While most welfare theorists argue that everyone has a right to a decent minimum level of health care, the WHO suggests that it is every human being's fundamental right to enjoy the highest attainable standard of health. However, I shall argue later that initial disagreement regarding what constitutes "basic health care" does not preclude the possibility that after reflection and communicative deliberation, people may come to overlapping consensus on what kinds of health-care services are most important.

Even if we assume that we all share certain health-care needs, libertarians are still suspicious of prescriptive needs statements. They believe that such statements are inconsistent with the ideas of treating people as ends in themselves and self-ownership.[73] Nozick (1974), whose libertarian theory is adopted by Engelhardt (1996), argues that individuals are separate entities with their own separate lives. Only individuals themselves can decide how they may want to live their lives and spend their resources. Others cannot interfere with people's autonomous decisions. Given this individualist view, Nozick and other libertarians argue that state authority can only be derived from consent given by the people. Each person is entitled to his or her justly-acquired resources, and has the negative right to decide what he or she wants to do with them. Nozick (1974) argues that a patterned distribution scheme, which "specifies that a distribution is to vary along with some natural dimension," ignores past circumstances and taxes unwilling individuals to establish universal health care (p. 156). He argues that patterned principles such as "distribute according to needs" treats resources "as if they appeared from nowhere, out of nothing" (p. 160). Such patterned distribution ignores the fact that resources "come into the world already attached to people having entitlements over them" (p. 160). Given that free transfer may regularly upset patterns, Nozick worries that redistribution to meet needs will continuously violate the individuals' negative right to dispose of their resources in whatever way they see fit.

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[71] For example, people may have different views on whether infertility, which is an impairment of normal species functioning, constitute unfair disadvantages that need to be corrected as a matter of justice.

[72] I shall argue in chapter four that an inclusive deliberative process can allow people to come to overlapping agreement on what a just health-care system may look like.

[73] While I do not employ the rights language, I shall argue in chapter four that redistribution to fulfil people's needs does not necessarily violate the principle of treating people as ends in themselves. Rights are not absolute and unlimited; they do allow limits in scope.

This individualist account of liberty right leads many libertarians to argue against the Rawlsian redistributive scheme that is adopted by both Green (1976, 1983) and Daniels (1985). Libertarians argue that each autonomous individual, who decides his or her life goals, is also responsible for his own health-care costs, *so long as others are not the cause of such condition or health-care needs.* Even though liberals such as Daniels may be correct in arguing that people's health conditions are often not their own fault, libertarians remind us that these health conditions are not results of *others'* faults either. Libertarians believe that just because some people are suffering from undeserved or morally arbitrary disadvantages does not imply that they have a claim right to the resources owned by others. Certainly, people who care about the well being of those who are in poor economic and health conditions may want to provide universal access to health care by voluntarily contributing to a public health-care scheme. However, it is not the role of the government to step in and coerce contributions from the citizens, even if such voluntary donations are shown to be inadequate in providing health care for everyone. Nozick (1974) argues that respect for people's liberty simply prohibits coercive redistribution of resources.[74]

This line of reasoning is echoed by other libertarians. As Jan Narveson (1993) puts it, rather than coercing people to help some to pursue their projects and purposes for which they have no sympathy whatsoever, people should simply all agree to respect each other's pursuits (p. 143). He argues that we need to "draw a sort of line around each person, and insist that others not cross that line without the permission of the occupant" (Narveson, 1993, 143). When people respect each other's boundary, they can then live as they see fit, with only their bumpings into each other being subject to public control.[75] If people did not cause others' health conditions, they should be free to choose whether they want to contribute to help others gain access to various health-care services.

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[74] As we shall see in chapter four, one may question whether even minimal coercion (e.g., taxing 0.0001% of people's income) is *always* unjustifiable.

[75] However, one may argue that it is unlikely that those indigent whose needs are

Perhaps libertarians may borrow the social constructionists' argument in denying the inevitability of the concept of right to health care or any other welfare rights. Some advocates of a right to health care assume that this right is given or inevitable. They argue that welfare rights are human rights that belong to everyone and are indisputable. As we saw in the last chapter, contemporary philosophers who argue for right-based ethics usually believe that human rights are independent of institutional designs. Libertarians may point out that, although there are disagreements of the concept of health-care rights and what constitute a just health-care system, some still uncritically take these notions for granted. This shows that the so-called welfare rights are not, to use Hacking's (1999) language, discovered in the natural world but are created or constructed by some people for various political purposes. How we understand such created right or why we may want to create such a right depends on human interaction and social condition. Economic and social conditions, for example, have significant effect on how a society thinks about its social goods, including whether it wants to establish various welfare programs.[76] The way that people see themselves and their relationships with others can also have impact on whether they want to voluntarily contribute to establish a legal right to health care and provide essential services for those who cannot afford them by their own efforts.[77] In other words, a "right to health care" is created by people and does not exist independent of such social establishment.

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unmet can "live as they see fit." As we saw in the last chapter, some welfare-rights theorists argue that people can only live autonomously if their needs are met.

[76] For example, even Doyal and Gough (1991), who argue that people have a right to have their health-care needs satisfied, insist that for this right to occur, certain political and economic preconditions must be fulfilled.

[77] Libertarians think that a legal right to health care can only be established legitimately if we employ voluntary donation to set up such program. Coercive redistribution to provide access to health-care services is still illegitimate under the libertarian doctrine.

Other Problems of the Rights Language

I shall argue in chapter 4 that there are good reasons to establish universal health care, even if that requires coercing some unwilling individuals to contribute. I shall also argue that such welfare programs do not necessarily violate these unwilling contributors' autonomy. However, saying that coercive redistribution is justifiable does not imply that the legitimacy is founded on the assumption of a right to health care. The notion of a moral right to health care is too abstract and contestable to be used as a sole foundational basis for publicly-funded health care. In what follows, let us briefly examine some confusions of the idea of right to health care.

As we saw in the last chapter, the concept of right is often seen as a correlative of an obligation. As O'Neill (1986) says, on an abstract level "there is no difference between a principle of obligation and a principle of right" (p. 99).[78] Although many people have argued against the usefulness of the correlativity principle, it does seem difficult to talk about rights in a meaningful way without somehow accepting or presupposing this principle.[79] After all, without correlativity, "discourse about what is owed by some cannot show that action ought to be taken, and discourse about what is owed by some cannot show that anyone (specified or unspecified) has been wronged if nothing is done" (p. 99). When we talk about rights, "we assume a framework in which performance of obligations can be claimed" (p. 100). We also assume that the "obligations are owed to specified [rights holders]" (p. 100). In general, rights holders "can press their claims only when the obligations to meet these claims have been allocated to specified bearers of obligations" (p. 100).[80] If we assume that there is a universal right to food, but that the obligation to provide food to each claimant is not "actually allocated to specified agents and agencies, this 'right' will provide meagre pickings" (O'Neill, 1986, 101). In other words, if obligation bearers are unidentifiable by rights holder, claims to have rights amount only to rhetoric that proclaim manifesto rights against unspecified others (O'Neill, 1996). If we simply talk about rights without having pre-established institutions "for distributing or allocation specific obligations, there is systematic unclarity about whether one can speak of violators" (O'Neill, 1996, 132).

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[78] O'Neill (1986) observes that "in many European languages the same word is used to express the notions of right and of obligation" (p. 99).

[79] One of the reasons why many people find the correlativity principle unconvincing is that there seems to be duties that generate no rights and rights that generate no obligations. However, for those who are convinced by the correlativity thesis, they may argue that if these alleged rights do not have correlative obligations or obligation holders, they are simply not rights.

If we apply the correlativity thesis to the alleged right to health care, it seems that we can only talk about such a right meaningfully if we can identify the correlative obligation-bearers who have to fulfil such rights. However, the problem is to identify who exactly bears the obligation or responsibility to help someone that allegedly has a right to health care. The relatives who can afford extra bills? The family who lives in the big mansion and owns the oil company in town? The affluent people from other countries? The doctors in town who have the expertise to treat the patient? Or all of the above? As Wellman (1982) points out, the conceptual problem of talking about claim right to welfare is that the need of the poor does not identify any second party who has the corresponding duty to provide that benefit to the poor. While we may agree that those who are in close kinship with me should help me in situations where I am stranded, it is unclear how independent of established institutions I am entitled to be helped by moral strangers who did not cause my conditions. In other words, one of the difficulties in understanding welfare right independent of any established institutions is that it is often unclear who the correlative duty-bearers are, and how much one is "entitled" to. Assuming that I possess a moral right to health care, can I actually point at someone and claim that he has the correlative duty to meet my health-care needs, even if he has never heard of me and that no institution has been set up?[81] If I need an organ transplant to survive, can I say that someone is obligated to donate an organ and that a surgeon is obligated to perform the transplant for me? If so, who exactly is that "someone?" To put the matter of correlativity in another way, if I need certain medical treatments to restore my functioning but such procedures are not made available to me, who exactly has failed in her obligation or duty?

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[80] As O'Neill (1986) says, "*unallocated* right action, which is owed to unspecified others, tends to drop out of sight" (p. 100; italics original).

[81] We can see that this example also has implications on third-world problems. If

Can we solve the problem of correlativity and avoid the issue of institution by arguing that a welfare right is a "in rem" right[82] against everyone, so that everyone has an obligation to help those in need? Such a notion of universal obligation may take care of the question of who the obligation-bearers are without having to first establish various institutions to assign specific obligations.

However, it is still unclear how we can talk about universal obligation to provide health care without specifying the roles of these obligation bearers and the extent of their obligations. O'Neill (1998) argues that it is difficult to talk about a universal obligation to provide welfare in an abstract way. While it seems plausible to think that liberty rights are matched by and require universal obligations not to interfere, it seems implausible to translate a universal right to health care into a universal obligation to provide a specific amount of such services. In terms of liberty rights, it is quite clear who has violated whose rights. For example, even in the absence of enforcement, if "A tortures B, we are quite clear who has violated B's right" (p. 103). However, if A does not provide B with the resources necessary to acquire health care, it is unclear whether A has violated B's rights. If we have

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human beings all possess the right to health care, then it seems that people from other countries can have legitimate claims on us to provide them with similar quality of health care and other sources of life.

[82] As Feinberg (1973) points out, generally speaking in rem rights are negative rights. While he is sympathetic to the idea of "manifesto rights," which are not actual rights and are not correlated to another's duty, he realizes that such language is only used by manifesto writers as a rhetorical license to express "the conviction that they ought to be recognized by states as potential rights and consequently as determinants of present aspirations and guides to present policies" (p. 67).

not already established institutions to assign specific obligations to people, it is unclear how we can enforce B's alleged right to health care.

The second reason why the concept of welfare right is controversial and confusing is that it seems inconsistent with our negative right to liberty, since it allows individuals or the state to coerce unwilling strangers to give up part of their property. Nozick (1974), as I mentioned, argues that liberty is one moral right that every moral agent shares. The right to liberty guarantees each individual the negative rights to life and self-ownership. This right to liberty promises that each individual can choose his or her own ends in whatever way he or she sees fit. This includes being able to adopt whatever values one sees suitable for one's life, and to spend one's justly acquired resources in one's own way.[83] Given such right, it seems that coercive redistribution cannot be an actual right, since it contradicts the liberty right.[84] If we think about Green's (1976,1983) attempt to put health care on par with basic liberties, it seems that he has to explain how respect for such liberties is consistent with granting a right to health care. After all, enforcing a right to health care requires coercive redistribution of people's resources, which appears to violate people's liberty right to control their resources.[85]

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[83] Hospers (1992) is also troubled by how welfare rights theorists believe that the government can force people to contribute to various social programs. He claims that property right is as basic as "rights of life and liberty," since "without property rights no other rights are possible" (p. 43).

[84] However, one may argue that the proponents of negative rights bear the burden of explaining why such rights are inviolable. Nonetheless, since negative rights only require inaction but welfare rights require positive actions, it seems that proponents of welfare rights bear the burden to show that they actually are *entitled* to disturb others' autonomy.

[85] Onora O'Neill (1998) argues that whether a right could be universally enjoyed depends on "whether the right is *internally* consistent [and] also whether it is consistent with all other members of a proposed set of rights" (p. 105; italics original). If welfare rights cannot consistently exist with liberty rights, and we also agree with Hart in thinking that liberty rights are fundamental, then we need to rethink about whether we can still argue for the existence of welfare rights.

Certainly, one may argue that liberty rights are compatible with welfare rights if we reconsider how fulfilment of basic needs is necessary for one to live an autonomous life. As we saw in the last chapter, some argue that people can only live an autonomous life if their basic needs are met (Shue, 1980; Copp, 1992, 1998; Gewirth, 1996). However, what these theorists need to answer is whether we can "redistribute freedom" across individuals. Specifically, welfare rights theorists who employ the autonomy argument seem to be saying that we can limit one person's freedom to help promote another's freedom. The problem, however, is that the right to freedom by itself says nothing about the legitimacy of redistributing freedom in such a way.

The third problem of the alleged right to health care lies in the ambiguity of who the rights bearers may be. For example, one may ask whether the alleged right to health care is one of the universal human rights that belong to everyone simply in virtue of being a person. Many who answer affirmatively to this question refer to article 25 of the UN *Declaration of Human Rights*. This manifesto states that everyone "has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control" (Nickel, 1987, 185). On the surface, this does sound like the United Nations is advocating a universal welfare right that belongs to every human being. However, what many have ignored is the last part of this statement, which suggests that one has such a right *if* one is put into needy conditions because of "circumstances beyond [one's] control." In other words, it seems that even if we assume that the UN *Declaration* is talking about actual rights and not simply aspirations that should guide policy makers, this manifesto does not suggest that *everyone*, regardless of his situation, has an unqualified right to health care. The article only suggests that one has a right to basic health care and other social services if one is incapable of meeting such needs because of various *uncontrollable* factors.

However, we still need to examine what the qualifications mean here. For example, does one still have a right to *tax-funded* health care if one is responsible for one's needy condition? Also, do people who can afford their own health care also have a right to have their health-care needs met by others?

Regarding the issue of responsibility, if an individual did not work simply because he felt "unmotivated" or did not care about taking any reasonable precaution to prevent injuries or illnesses, it seems that one can say that this individual could have controlled his behaviour and avoided his illnesses.[86] Regarding the issue of whether people can afford their own health care, the manifesto does not tell us exactly how we can test whether people have the means to acquire health care. It also does not explain whether individuals who are well off still have a right to ask others to pay for their services.[87]

Perhaps we can examine some of the background assumptions or value judgements behind this UN article.[88] It seems that we can understand the article as implying that no one should be stranded and endangered because of something beyond one's control, i.e., something that is morally arbitrary.[89] Daniels (1985), as we saw in the last chapter, echoes this argument. However, what is interesting about the background assumption of this article is that, while this article may apply to everyone, it has a "limited application." It seems only to grant an individual the right to health care if the individual is not responsible for his health condition and can show that he does not have the necessary means to purchase health care on his own. If it turns out that the individual has somehow caused his own conditions, i.e., the circumstances are *not* beyond his control, then it is questionable whether he may have forfeited his "right" or is no longer entitled to others' help.

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[86] I shall discuss the concern and problem of this responsibility account in chapter 5.

[87] Suppose a person does not currently have any cash to pay for a life-saving surgery. However, if he sells his apartment and all his furniture, he will have just enough money for the surgery. Can this person "afford" his surgery? Is he entitled to be helped by others to pay for his medical bills?

[88] Beauchamp (1991) believes that we should understand this article not as strict human rights but as guiding ideals of what a society should strive for.

[89] However, one may argue that we can only deny an individual her right o health care if we can show that the patient's poor economic and health conditions are absolutely not related to discriminatory attitudes and policies that are under the patient's control.

The fourth concern about the alleged right to health care is that it is unclear what precisely is the scope of our obligations (Beauchamp, 1991). Put in another way, it is simply unclear to what kind or how much health care one is entitled (Halper, 1991). For example, do we have a right to a decent minimum level of health care, or do we have a right to the best available treatment? As I mentioned, various writers have disagreed on the scope of the right to health care. Certainly, if we adopt the idea that one has a right to the best available treatment, we may run into the risk of falling into the bottomless pit, to use Daniels' (1985) language. It is sometimes argued that political talk of a right to health care is dangerous partly because it seems to imply that one is entitled to any desirable health-care services, regardless of how expensive that may be. So long as the treatment is considered desirable to ameliorate harm, the patient is entitled to it. However, we can imagine that sometimes the best available remedies for certain diseases or injuries may be extremely expensive and the society probably cannot provide such procedures to every patient without sacrificing other important social goods. If we accept the claim that everyone has a right to best available care, then it seems that a politically sound government has to provide such services regardless of the costs.[90] Nonetheless, the obvious concern here is that the demand can be so high that an attempt to provide these services may bankrupt the system or at least force the society to forgo many other important services.

Certainly, one may argue that a right to health care does not imply an unlimited right, but a right that is conditional to the resources available in the society. As we saw before, Green (1976, 1983), Copp (1992, 1998), and Nielsen (1984) all seem to think that a right to health care is subject to available resources. But the question is, is the notion of *qualified* right to health care itself helpful?

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[90] Perhaps the question is also whether the phrase "medically necessary" is a synonym with "basic health care." One may argue that these phrases are interchangeable and that the qualifier "basic" has no bearing on whether the service is expensive. In other words, even if some services may be extremely expensive, a commitment to provide basic health care may imply that the government still has to fund such services, so long as they are deemed medically necessary.

Two of the issues that we need to deal with are how exactly we should qualify this right and how we can decide affordability. In thinking about the method of qualification, do we base the qualification on age, costs of treatment, or responsibility? In other words, do we base our qualification on factors about the patient, or do we base it on factors about the treatment? As we shall see in a later chapter, while all these qualifications will have to be considered, they all have their own problems and thus are themselves questionable qualifiers. So in the end it is unclear that even a theory of qualified right can clarify the issues.

And in dealing with the question of how much the society can afford, it seems that the notion of a qualified right by itself does not provide guidance to determine "affordability." For example, Green argues that people have a right to the highest attainable level of health care *that the society can afford*. However, he does not explain exactly how we may determine what the society can afford when multiple factors are at stake. Certainly, we can "afford" more health care if we charge high taxes or do not put our resources into any other areas. Nonetheless, it is unclear if these are desirable options. So, in the end anyone who argues for welfare rights must rethink the relative importance of other social goods such as education and housing. They must also consider how respect for people's autonomy may put a limit on how much resource can be redistributed.[91] Simply saying that we ought to qualify the right to health care according to what the society can afford does not take us very far.

So it seems that while the slogan "a right to health care" often carries strong rhetorical force, this concept poses more questions than answers. In other words, it is unclear that such a contestable concept of health-care right can provide an "easy" or "obvious" justification for publicly-funded health care as the rights theorists may have hoped.

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[91] I shall briefly discuss how the deliberative parties may decide on these matters in chapter 5.

Conclusion

In this chapter, I have presented various concerns regarding the needs language and the concept of a right to health care. I have also argued that the rights language is too abstract and confusing to serve as a sole foundational basis for publicly-funded health care. However, it is unclear that establishment of tax-funded universal health care is only justified if we have a moral right to such services. In the following chapter, I shall argue that redistribution to finance universal health care can be justified if we abandon the atomist individualist notion of consent and instead adopt an inclusive deliberative approach in deciding what kinds of a system can address the needs of various individuals and groups.

CHAPTER THREE

THE NEED FOR A DELIBERATIVE PROCESS

As we saw in the last chapter, the concept of a right to health care is confusing, and therefore does not provide a solid justification for tax-funded health care. I have also presented the libertarian argument against redistribution to finance universal health care. In the next chapter, I shall argue that tax-funded universal health care can still be implemented without violating people's autonomy. Even if we do not possess welfare rights, there are still other good reasons why the establishment of a tax-funded health-care scheme is justifiable or perhaps even required. In this chapter, I shall first examine some problems with the libertarian emphasis on contract as the only basis for obligation, which is the main reason why libertarians vehemently argue against tax-funded health care and other welfare programs. I shall argue that consent or explicit agreements are not the only sources of moral obligation. Obligations can also be based on certain principles of justice. Obligations can also arise out of other social relationships that are not contract-based. I shall also argue that, while the concepts of consent and respect for autonomy are important in any legitimate political process, that does not imply that every act of consent has the same significance. Some reasons for consent or dissent are better than others, and some people may or may not reflect on the issues before providing consent or dissent. In deciding whether a particular policy can legitimately be implemented, we must consider these factors. I shall argue that the best way for people in a pluralistic state to arrive at informed consent or dissent is by adopting the inclusive deliberative approach that provides people the opportunity to reflect with each other on various issues. Based on the deliberative democratic model developed by Gutmann and Thompson (1996), the inclusive deliberative approach that I shall propose can help reflective citizens to discuss and think through various perspectives before making their decisions. It can help them clarify various abstract notions, such as the extent of our obligations to others. More importantly, the deliberative approach can help promote civic orientation among the citizens and help them to form and work towards various common goals.

Atomist Individualism and Libertarianism

As I pointed out in the last chapter, libertarians are suspicious of redistribution to provide universal health care. They believe that compulsory taxation to provide others' subjective needs is inconsistent with the Kantian ideas of treating people as ends in themselves and self-ownership. Many libertarians hold an individualist view and argue that we should all respect each other's boundaries (Nozick, 1974; Machan, 1989; Hospers, 1992; Narveson, 1993; Engelhardt, 1996). While they in general agree that it is unfortunate that some people are in disadvantaged positions and that it may be admirable for people to help such individuals, they disagree with the liberal contention that even people who did not cause such disadvantages have an obligation to correct them. Libertarians especially reject the claim that the government may coerce unwilling citizens to contribute to programs designed to minimize these disadvantages. Libertarians argue that an individual has a right to dispose of her resources in whatever way she desires, so that only she can decide whether she wants to lend a hand to those in need. If the individual has not given consent to others to act on her behalf, others may not do so. For example, they may not "decide for her" what kind of a health-care system is good, or how much of her income should go into socialized medicine to help those who are in disadvantaged positions. Doing so, libertarians argue, is equivalent to using the individual as a mere means and violates the individual's rational agency.

This concept of moral individualism has gained wide acceptance in recent centuries, especially in English-speaking societies. The modern anti-authoritarian tendency to frame the immunities accorded people by constitutions and laws in terms of subjective rights puts the autonomous individual at the centre of the North American legal system (Taylor, 1989a). People "start off as political atoms" who are by nature sovereign individuals and are not bound to any authority (pp. 193-4). According to this atomist notion, people are free and politically disengaged. This idea that individuals have total control over their lives and do not depend on anyone else has led to the doctrine that only individuals themselves can create the obligation to obey, since the individuals' wills and their purposes are their own.

In an early work, Nozick (1974) argues for this moral individualism. He says that each individual is a separate person, and his is the only life he has. This atomist view does not define individuals by their membership in any particular economic or social relationship, but assumes that individuals are free to question and reject any particular relationship. In other words, while social cooperation is unnecessary and unavoidable, it is not considered something inherently valuable, but only a means to fulfil the interests that are not available through individual efforts. As Nozick (1974) explains in his conception of the night-watchman state, separate individuals choose whether they want to join a minimal state. If they do not think that they can protect themselves effectively, they may want to join others who have similar interests to establish a minimal state. However, if they believe that their individual effort is adequate or they are against the ideologies or methods used by the state or simply do not want to join the state, they are free to remain independents. In fact, even those who choose to join the minimal state still remain separate individuals who are free to pursue their own goals. After all, the purpose of the minimal state is not to bind people together to form a social unit but to provide a mechanism to ensure that individuals can continue to enjoy independence of their actions. This atomist view is initially attractive because it aims at giving individuals power and control. It allows them to detach themselves from any particular social practice and relationship. Individuals decide for themselves whether they are self-sufficient. They also determine how they want to conduct their own lives and fulfil their interests. They are free to determine what kind of relationships they want to have with others and what endeavours they want or do not want to support. In this way, individuals are considered the constructors of their own character rather than passive beings who simply follow the telos of society and nature (Taylor, 1989a). By enjoying individual independence and autonomy, one has full authority over oneself.

Contractual Theory of Obligation

What comes with this atomist account of moral autonomy is the idea of contractual obligation: individuals are self-legislators who are obligated to perform certain actions only if they have voluntarily entered into an agreement with others to perform such actions.[92]

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[92] Libertarians do allow an exception to this consent/contract rule. If an individual

According to this doctrine of contractual obligation, "you do not have a contractual obligation unless you agree to it, and if you agree to it, you have it – you are bound, precisely because you agreed" (Smith, 1998, 132).[93] In thinking about whether an individual has an enforceable obligation to contribute to universal health care, the libertarian notion of contractual obligation says that we simply need to see whether the individual has agreed to make contribution. If she has explicitly consented to give up some of her resources to set up health care for all, then she is obliged to do so. However, if she has not committed herself to such a scheme, no one can force her to pay.

A few characteristics about this contract-based theory of obligation are worth noting. First, this theory of contractual obligations focuses on enforceability and the potential "contractor." Unlike many theories of *moral* obligation that focus on the conditions of potential recipients, such as whether these individuals are in dire situation and need our help, this contractual account of obligation is an account of political obligation, i.e., obligation that may legitimately be enforced by the state.[94] It looks only at whether an individual herself has agreed to become a contractor.[95] By deciding whether she wants to enter into an agreement with others, she herself freely chooses whether she wants to take on a political obligation. In this way, an individual has an enforceable obligation to do something only if she has agreed

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has violated other people's rights, then he is automatically obligated to compensate the victim. This constitutes the only exception to the consent rule.

[93] However, many philosophers who employ the contract notion do not talk about *actual* contract but hypothetical contract. For example, Rawls (1971) employs a social-contract theory that does not depend on what people have actually agreed to do. It focuses on what people have good reasons to do certain things.

[94] For the purpose of this thesis, I shall use the terms political obligation and enforceable obligation interchangeably.

[95] To put it in a different way, it seems that the content of the agreement is secondary. According to the theory of contractual obligation, what is important is the agreement itself. For example, if I have an obligation to help feed the hungry, it is not so much because these starving people may die, but rather because I have made an agreement to help them.

to fulfil such an obligation herself. For example, if Susan has entered into an agreement with others to help establish universal health care, then she has given others the authority to collect her contribution if she fails to put in her promised amount. However, if she does not agree to contribute, regardless of whether she has a moral obligation to contribute, others have no right to force her to pay.

To say that enforceable obligations are results of self-imposed contracts implies that they are subjective and discretionary. It also follows that all people do not have the same obligations. Under the contractual theory of obligation, whether you and I are obliged to feed the poor depends not on the needs of the poor or how the poor may be harmed if their needs are not fulfilled. Rather, it depends on whether we have done something ourselves to create an obligation. If I explicitly consented to contribute to help feed the poor, then I have an obligation to keep my agreement. If you did not agree to help these people, however, according to the libertarian theory of contractual obligation no one has the authority to force you to help. Certainly, if you somehow were the cause of these people's economic destitution, libertarians would agree that you now have an obligation to help or compensate them. However, if you were not the direct cause of these people's dire conditions, you have the autonomy to decide whether you want to help them, and no one could make that decision for you.

This contract-based theory of obligation also implies that an individual is obligated to participate only if she has entered into an agreement *with someone else*. The contract-based theory says that I only have an enforceable obligation to do X if I have promised *another person* that I will do X. If I have not made this agreement with another person, no one can force me to do X. Suppose I have been thinking about contributing to the universal health-care scheme because I believe that this will be the easiest way for me to get affordable services. Suppose also that I have even put aside some money for the possibility of making contribution in the future. According to the theory of contractual obligation, it seems that my putting aside the money does not give anyone the authority to force me to contribute right now or in the future. So long as I have not made an agreement with another person, I have no obligation to do anything. I am still free to "shop around" and see if other payment schemes may turn out to be better for me.

The atomist theory of contractual obligation also implies that enforceable obligations do not arise automatically out of interpersonal relationships or institutional arrangements. Regarding the issue of interpersonal relationships, it follows from the theory of contractual obligation that it is up to my friends and family members to decide whether they want to help me.[96] At the same time, no one can force me to help others either, regardless of our intimate relationship. In fact, according to the contractual theory of obligation, it seems that no one can force me to help my friends or family members *even if they have helped or supported me before*.

An example can shed some light on this issue. Suppose I lost my house and all my possessions in a fire. My best friend Nancy let me stay with her while I tried to put my life back together.[97] When I indicated my desire to rebuild my house, Nancy volunteered to lend me her life savings so I could afford to do so. I welcomed her help and promised her that I would pay her back every cent I borrowed. Eventually I did pay back my loan. And just when I had rebuilt my house and my life, misfortune hit Nancy. She lost her job and could not pay the mortgage, and in the end the bank took possession of her house. She even had to file for bankruptcy. Nancy came to me to see if I could help her. I did have a guest room in my house, and I could probably afford to lend her some money. But can anyone force me to let her stay with me or to lend her some money?

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[96] In the case of parental relationships, the contract-based theory of obligation implies that what my parents have done for me does not by itself create an obligation. After all, they cannot simply provide me with various benefits and then automatically expect me to repay them for their efforts. If I did not agree to support them when they grow old, I have no obligation to do so.

[97] According to the contractual theory, Nancy had no obligation to let me stay with her unless she had made a prior agreement with me.

It seems that libertarians who accept the contract or prior agreement as the sole basis for political obligation would say that I had an enforceable obligation to help Nancy only if I promised her explicitly that I would help her.[98] If Nancy never said that she would help me on the condition that I would help her in the future, and I never told her that I would let her stay with me, I had no obligation to do so. The only obligation I had to Nancy was to repay my loan, since I promised her I would do that. Once I paid that back, I had no further obligation. Certainly, I would still be free to lend a hand if I wanted to do so. However, according to the libertarian notion of obligation by contract, my friendship with Nancy by itself does not mean that I owed Nancy anything. In fact, even if I could not have rebuilt my house without Nancy's help, I still had no obligation to let her stay with me. Her prior help could be considered a gift to me. Without having agreed that I would let her stay with me when the need arose, I could legitimately turn Nancy away.[99]

The libertarian theory of contractual obligation also seems to imply that enforceable obligations do not arise out of institutional designs. Recall that one of the confusions of welfare rights is that it is unclear how much or what is owed to rights-bearers in the absence of established institutional regulations. However, even if the state has created various institutions to specify what it wants people to do, libertarians still do not think that people have an obligation to follow these institutions. Libertarians do not think that establishment of institutions automatically creates any political obligations for individuals. They argue that the state cannot simply create various institutions on behalf of their citizens and then tell them that they are obligated to follow the state's intention. Certainly, the citizens themselves may welcome these institutions and volunteer to contribute to such cause. However, without their agreement, the state cannot impose a binding obligation on them. For example, libertarians argue that the state cannot simply set up universal health care on behalf of their citizens and then assign obligation to them by forcing them to contribute. In order for the government to legitimately set up universal health care or any other policies, it has to acquire prior consent from its citizens. It is only when the citizens have agreed to contribute to the program that the government may enforce participation or collect resources to build such a program.[100] If the citizens refuse to contribute, the state has no authority to coerce redistribution. The atomist approach tells us that the individual herself has to agree to take on an obligation to help. In other words, if the citizen does not or even refuses to enter an agreement to contribute to help others, she has no obligation to contribute.

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[98] The libertarian notion of contractual obligation implies that I may still be obligated to help Nancy if I promised someone else (e.g., Nancy's mother) to help her.

[99] In fact, even if the person who helped me out was my mother, who had also supported me all my life, it seems that under the libertarian notion of obligation, I still owed my mother nothing.

Reasons for Using Consent/Contract as Ultimate Basis for Enforceable Obligation

I shall discuss some problems of the contractual theory of obligation in the next section. Here I want to focus on why libertarians put so much emphasis on explicit agreement as the sole criterion for enforceable or political obligation. Libertarians believe that politically enforceable obligations only arise out of explicit consent probably because they think that this is necessary to protect people's autonomy and independence. As I pointed out in the last chapter, Engelhardt and other libertarians believe that people have various negative rights that cannot be violated. They believe that violation of such rights represents a disrespect for these people's autonomy, since it implies that people cannot make decisions on their own. Rational individuals are capable of deciding for themselves how they want to spend their justly-acquired resources, and no one else should usurp the decision-making power from them.

Libertarians believe that consent should be the ultimate basis for political obligation for another reason. They observe that people in a pluralistic state have different and often incompatible moral visions. These diverse views sometimes lead people to fundamentally disagree on what they are obligated to do and the extent of their obligation. Given that each person has her own starting premises for a theory of distribution and life plans, Engelhardt argues that contribution decisions should be left up to each individual. He believes that the state has no access to objective moral truths and therefore is not qualified to resolve moral dilemmas or decide what obligations we all have. In this way, it is simply unjustified for the state to decide for its citizens how they should live their lives or spend their resources. People have their own self-chosen life plans, and they are the best judges of the best means to promote their well-being or interests. They should also be the ones to determine what moral schemes to follow. If they believe that a universal health-care scheme serves their well-being or is the morally correct scheme, they would automatically join such cooperative effort. However, if they do not think that such a system promotes their interests or is morally desirable, they would not want to participate. So if the state coerces redistribution, it will probably be going against these people's interests. For example, some people may want to invest in the stock market rather than contribute to a health-care scheme. They may prefer to pay for their health-care services out-of-pocket. Others may want to put money into the arts and purchase private insurance schemes. Forcing them to invest in the health-care scheme instead will be going against the people's own life goals. In this way, libertarians believe that it is illegitimate for the government or any other centralized institution to decide on behalf of its citizens that universal health care is desirable or that they are obligated to participate in establishing such projects. A theory of obligation that is grounded on consent or contract allows the state to remain neutral among various moral visions and personal decisions, including how people may want to spend their resources. Allowing individuals to be self-legislating, it respects the dignity of autonomous persons who are able to formulate their own rules and act according to them (Smith, 1998).

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[100] It seems that the same principle applies to policies that do not involve redistribution of resources. Even if the government wants to institutionalize certain laws, the contractual theory of obligations requires that it acquire agreement from the citizens. Otherwise they have no obligation to follow these laws.

In allowing people to make choices about their own lives without interference from others, this contractual conception of obligation certainly has some intuitive appeal. First, it allows people to decide how they want to live their lives and what endeavours may promote their interests and moral visions. Second, it recognizes that conflicting but perhaps equally reasonable moral values exist. It acknowledges that sometimes it seems difficult, if not impossible, to decide which of these conflicting views is preferable. When we do not have perfect knowledge of what distributive principle is the correct one, it is questionable whether we can legitimately construct a theory of obligation and impose it on everyone. In this way, respect for people's choices and uncertainty of the correct moral vision seem to demand that people be allowed to make their own decisions about their obligations.

Reasons for Dissent

If respect for autonomy is important, the question is whether we can whether we can coerce others to cooperate against their will. Libertarians may point out that people in a pluralistic state have different views on what moral obligations they owe others. If we do not have access to the moral truth, we may not be able to settle these differences and legitimately force people to adopt one view over another. If people do not consent to a particular arrangement, it seems that they have indicated that this arrangement is against their life goals or moral visions. If we still try to go against their wishes and force them to participate, we violate their autonomy.

The objection to forcing people to cooperate seems to be based on the assumption that rational persons always consent or dissent based on their careful judgements about what serve their interests or promote their goals. So if a certain endeavour is worthwhile or beneficial to these individuals, each individual will agree to contribute to such projects. For example, as we saw in the last chapter, Nozick (1974) believes that people who worry about their rights being violated by other equally self-interested individuals would voluntarily join a strong protective agency and eventually establish a minimal state.[101] If certain individuals do not wish to participate or join the state, it is because they do not think that such a state matches their personal goals or moral visions. Libertarians seem to believe that an individual's agreement or refusal to contribute to a health-care system shows whether he believes such a system can promote his interests or is consistent with his moral values.

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[101] A full discussion of the emergence of the Nozickian minimal state is beyond the scope of this chapter. See Nozick (1974).

However, non-contribution and reluctance to enter an agreement may not be the result of certain endeavour conflicting with one's life goals. There are other possible explanations for such hesitation to cooperate. In dealing with the issue of what kind of a health-care system they would support, individuals may not have all the information regarding the risk factors and so on, and they may underestimate the possible impacts of these factors. For example, individuals may not have sufficient information regarding the impact of cooperation versus non cooperation or may not interpret the available information correctly. We can also imagine that many people may not have thought about various issues involved in the cooperation scheme. They may refuse to cooperate even though they have not thought about the advantages and disadvantages of these policies or schemes. For example, they may simply base their decisions on what the majority of the people believe, even though they have not investigated the reasons behind the majority's preferences either. Even for those who have thought of such issues, predictive uncertainty may make it difficult for people to decide whether their individual efforts may in fact bring about similar benefits compared to the cooperation scheme.

The possibility of inadequate information and predictive uncertainty may lead people to simply discount the possibility of certain events happening and thus make irrational choices or to vote against their own preferences. As Gerald Dworkin (1983) argues, some people may irrationally vote against certain policies that are in fact in accordance with their own conception of the good. For example, people in general do not want to get hurt.[102] However, many of them vote against laws that are designed to protect them. For instance, many motorists and motorcyclists who do not want to die prematurely vote against seatbelt laws or refuse to wear helmets while riding motorcycles. Does it mean that respect for their rational choices preclude implementation of these laws? If we believe that people's choices truly represent their interests, we may have an obligation to refrain from acting against their decisions. However, as Gerald Dworkin (1983) argues, these people's dissents may not show their rational choices. These people may have irrationally placed another value, such as freedom from wearing a seatbelt or helmet, above that of physical well being, even though they themselves want to be protected from injury. Gerald Dworkin (1983) contends that, in these cases, the individuals who refuse to wear seatbelts or helmets either do not fully appreciate the danger involved or underestimate the likelihood of accidents happening. In other words, libertarians' assumption that people only dissent in cases where the proposed law is against their interest seems to be mistaken. People may refuse to consent to certain policies even when these policies are in their interests.

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[102] However, it is possible that some of those who vote against seatbelt laws are not against wearing seatbelts but only against the paternalistic laws. They may still wear their seatbelts every time when they ride in a car. They simply are against having laws that force them to do so. For the purpose of my argument here, I only concentrate on those who vote against the seatbelt laws and also refuse to wear the seatbelt.

One's irrational reluctance to cooperate can also be shown in other situations. Libertarians assume that when people desire certain goods and services that cannot be produced by individual efforts, they will automatically agree to join some cooperative scheme. If they do not wish to join such effort, it is because they are not interested in such services, and others should not force them to participate. However, it seems that people's reluctance to cooperate may be a result of extreme and perhaps irrational suspicion against certain organizations. It seems that people who are very concerned about individual freedom may worry that the agencies that must be created to fulfil their desires will be too big or too restrictive. For example, people may want to have affordable health care, but they may worry that the large-scale organizations that are necessary to provide effective and efficient services may be too large and beyond the control of individual members. Even though these large-scale organizations have a more secure foundation and can perform a diversity of tasks that may not be possible on individual efforts, some people may irrationally vote against them (Smith, 1998). They may be too worried about giving away their individual freedom when they subject themselves to various obligations. In the end, even though these individuals may really want to have access to certain services that can only be provided by large-scale schemes, they may irrationally confine themselves to small cooperative projects that may not be able to efficiently and effectively fulfil the members' goals.

Necessity of an Alternative Political Decision-Making Process

The possibilities that people may vote unreflectively and irrationally remind us that we have to qualify the criterion of contract or consent. Contrary to what libertarians seem to believe, people's actual consent may not reflect their life plans or reflective values. In this way, it is questionable that actual consent or contract by itself is meaningful. It is also unclear that implementing policies against irrational or unreflective dissent violates people's autonomy. In the following section, I argue that we should not put too much weight on actual consent or dissent itself. We should redirect our focus on *why* people may agree or disagree with certain policies. We should think of their consent or dissent as conclusions of processes of judgements. In other words, we should concentrate on the process of arriving at such conclusions as well as the conclusions themselves.

Part of the problem of the libertarian criterion of consent is that it does not consider whether people have good or bad reasons to consent to particular policies or cooperative schemes. It seems that libertarians take consent at face value and assume that every consent and dissent is of equal significance. Libertarians seem to think that if people consent to a policy, it is in accord with respect for people's autonomy and thus automatically legitimate for the state to carry out such a policy. If people do not consent, it necessarily means that such policy cannot be legitimately implemented, since implementing such policy is in conflict with people's life plans or moral visions and violates people's autonomy. This approach assumes that all forms of reluctance to cooperate are politically equivalent and does not differentiate reasonable from unreasonable reluctance to cooperate. It also does not consider the possibility that there may be good reasons why people *should* consent to certain policies.

Perhaps libertarians' reluctance to differentiate reasonable from unreasonable consent is once again the result of their skepticism. They do not think that we can legitimately judge the merit of various moral visions. They worry that any attempt to evaluate people's reasoning is an authoritarian tactic to take away people's autonomy.

However, the presence of multiple viewpoints does not imply that we cannot distinguish better from worse viewpoints. It also does not imply that we have to accept extreme relativism or subjectivism. We may still be able to say that some opinions are better than others, or that some justifications for these opinions are stronger than the rest. As Nussbaum (1992) observes, throughout history the exchange of reasons and arguments has allowed us to distinguish good things from bad things, and sound arguments from unsound ones. For example, if people's decision to vote against a universal health-care system is clearly in conflict with their own conceptions of their interests, then it seems that we can say that their reluctance to consent is irrational. In this way, even if we implement universal health care in spite of people's refusal to consent, it does not seem that we have violated their autonomy.[103]

In other words, if our goal is to protect people's autonomous choices, we should not simply say that consent is necessary for legitimate policies and government actions. We need to consider why certain people may or may not consent to various policies, and whether they may be choosing against their own interests. As we shall see shortly, a deliberative process allows citizens to gather information regarding various political issues and think through them with each other. It provides valuable opportunities for people to discuss with and explain to each other their respective concerns and why they may or may not support various policies. For example, a deliberative process allows people to reflect with each other on how such a system may affect them respectively and to examine why people may or may not agree to contribute to such a cooperative scheme.

When people deliberate with each other, they will realize that others may hold different perspectives from them. The face-to-face discussions allow them to see *who* holds various opinions. This is important, I argue, because various policies have different effects on different population groups. Sometimes a particular policy only affects a specific group, and it seems that we have good reason to only consider the consent of those who are bound by such policies. After all, if one is not bound by certain policies, then even if the state implements policies against one's wishes, it is unclear that one's autonomy is being violated.

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[103] I shall argue later in the chapter that people who enter a deliberative process with their fellow citizens will probably realize that a universal and tax-funded health-care system is in their best interests.

If their chances of successfully carrying out their self-chosen life plans are not affected by such policies, their consent may not be morally relevant.

The public decision process employed by the Oregon Plan provides some insight on why we need to be careful of who the people are that provide consent. When the state of Oregon first proposed to increase health insurance coverage for many of the state's uninsured residents by rationing certain services that were at the time available to medicaid recipients, it tried to solicit responses and comments from the public. Officials held town meetings and polled people to find out what services they thought should be covered. Some have claimed that the public debate "was structured as an open process with a fair amount of public input" (Strosberg, 1992, 5). In other words, it seems that people's opinions were put into account, and thus the plan apparently took the criterion of consent seriously. However, what is worth noting is that "most of the input has been from the upper-middle class" (Strosberg, 1992, 5). While the medicaid recipients were the ones who were most affected because they had to forgo certain beneficial services to help expand coverage to large numbers of people who had no health insurance, those in upper-middle class were not required to make equivalent or even similar sacrifices. The plan did not require a tax increase, so basically the rich were not affected by it. In this way, the composition of the meetings and surveys was not representative of the population affected by the rationing plan (Daniels, 1992). The comments or suggestions collected at these meetings therefore did not reflect the concerns of those who were bound by the plan. As we saw in the last chapter, social constructionists are worried about who make decisions regarding how welfare programs should run. If the well-off individuals were not affected by the decisions, it seems that there are good reasons to at least discount the opinion of such people and to actively seek participation from those who would be affected and bound by such decisions, namely, those who were poor.[104]

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[104] The telephone survey discussed in the last chapter also shows the necessity of discounting the opinion of people who are not bound by the decisions. Able-bodied people were asked by the Oregon Plan officials to put themselves in the situation of a "disabled" person and think about how they may prioritize services for the "disabled." Since these people would not be bound or significantly affected by the decisions, one may argue that their opinions should not carry too much weight in deciding how services for the "disable"

The Alternative Political Decision-Making Process – The Inclusive Deliberative Approach

So far I have argued that a legitimate process of acquiring consent is much more complicated than simply polling separate individuals to see if they want to contribute to certain projects, such as universal health care. As I have said repeatedly, I do agree with libertarians that respect for people's autonomy is important in establishing legitimate policies that will affect the citizens. However, this does not imply that we cannot implement any policy that does not have unanimous consent. After all, there will possibly always be people who for one reason or another do not want to consent to various policies. But given that even a pluralistic society must adopt some form of health-care policies, we need to find a way that can deal with various allocation dilemmas. The question is whether it is possible for people of different and possibly incommensurable interests to reach consensus on policy decisions. If so, how may this political process work? In other words, what kind of political process is best in a pluralistic state in reaching policy decisions that can be fair to all? In this section, I will argue that when given the equal chance to deliberate with each other, people in a pluralistic state can reach overlapping consensus in determining various policies, including those on health-care resource allocation. This inclusive deliberative approach that I shall argue for is based on the democratic deliberative approach developed by Amy Gutmann and Dennis Thompson (1996; 1999) as well as Iris Marion Young (1999). I shall argue that a reflective deliberative process provides a helpful mechanism for reflective citizens to arrive at policies that *can* be accepted by those who will be bound by the decisions. This approach can help reflective citizens in making informed decisions regarding universal health care and other welfare programs. I further develop their arguments and propose that a legitimate decision-making process in a pluralist state that is inclusive, participatory, empowering, reciprocal, and public can help citizens reach fair agreements. Such an approach, which gathers citizens together from various backgrounds and provides them the opportunity to

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should be prioritized.

communicate with each other their respective interests, can help people in a pluralist state to become more cooperative and more willing to reach overlapping consensus in trying to accommodate various concerns.

A note of caution here. As I just mentioned, there will always be dissenters for any policy. However, I am only concerned with whether the decision-making process is fair and legitimate to all, so that the policies that result from such process will also be fair to everyone. When the decision process is legitimate, even if the resulting decisions may differ from what one may subjectively want, one ought to accept the decision on the ground that it is chosen by a fair process. In other words, once people agree that the decision-making process is legitimate, they cannot refuse to accept the outcome of the process.

As I mentioned, one may be skeptical that people with different or even conflicting interests would be able to deliberate with each other and reach agreements. However, I contend that two features of human beings are worth noting. First, most human beings are rational agents who recognize and value the social nature of rationality. They recognize that exposing their arguments to public scrutiny is one way of testing their own arguments. They also recognize that reasoning with others is one way to find out other reasons that they have not thought of before. Moreover, as rational beings, they want to present themselves to each other as reasonable persons who have good grounds for their positions and want others to accept their positions on such bases. They in general want others to agree with them and also only want to agree with others with good reasons. As we shall see shortly, democratic deliberation provides people the opportunity to explain to each other their respective positions and their reasoning behind such positions.

Second, I contend that people as social beings are in general cooperative beings. Human beings are not isolated entities but are related beings who in general do have compassion for or at least want to cooperate with those who are related to them in various ways. I shall argue that people's willingness to treat other as fellow citizens who are part of the same community will increase when certain conditions are in place. Such fellowship can encourage people to be more open-minded and prepared to listen to each other's concerns. In fact, as I shall argue shortly, people who see themselves as part of a community will see cooperation with their fellow community members not against but part of their own interests. Their self-interests will become incorporative, i.e., they will incorporate concern for others as part of their self interests.

Besides my assumptions of human nature, there are a few reasons why an inclusive deliberative approach is most appropriate and fair for making policy decisions in a pluralist state. One of the concerns in determining whether it is legitimate for a government to charge its citizens taxes to establish universal health care is how such a decision should be made and who should make this decision. Recall that libertarians and social constructionists are both suspicious of welfare programs partly due to the possibility that such programs are an authoritarian imposition of arbitrary measures. On the one hand, libertarians such as Nozick (1974) and Engelhardt (1996) are in general suspicious of welfare programs because they worry that those who are in power may arbitrarily choose certain conceptions of a good life and impose them on everyone. On the other hand, social constructionists such as Nancy Fraser (1989) do not deny the importance of welfare programs but worry that those who decide on the design and content of the welfare programs may not understand the interests and concerns of the recipients.

This concern of how policies are made is especially important in a pluralistic state, which is composed of people who may not share the same experiences and backgrounds. While people may all have some of the same basic life goals and needs, they differ in their history, culture, ethnicity, language, health status, economic and social backgrounds, and so on. Given the diversity in such conditions, health-care allocation policies may affect various groups differently. For example, decisions regarding whether the government should establish universal health care affect people in various economic positions in very different ways. While the poor people's health status can be drastically improved by a universal health plan, the financial freedom of those who are rich may be limited. Given that people of different backgrounds may not realize the various effects certain policy can have on others and the reason why they prefer different health-care schemes, we need to provide the opportunity for people to discuss with each other their respective concerns. We also have to ensure that the policies enacted do not attend only to the interests of certain population groups but those of all affected. To reach decisions that are fair to all parties in a pluralist state, we need a decision process that will present and consider the interests of various groups. As we shall see shortly, inclusion and representation are some of the implicit norms of democratic legitimacy. I shall argue that, only when these norms are fulfilled will the policies and political decisions be legitimate from pluralistic perspectives. These norms form the constitutional structure for the deliberative democratic process.

1. Inclusion

In order to make sure that social policies address the interests of all affected groups and individuals, I argue that a legitimate political process in a pluralistic state ought to meet the interests and concerns of not only some selected few but all who may be affected by such decisions. Echoing Young (1999), I argue that this concept of inclusion is the fundamental and perhaps the foundational norm that guides deliberative democracy. A political process is only fair or legitimate if it is inclusive. What this means is that the interests of all groups affected are represented such that the planning process ought to take into account the various interests, opinions, and perspectives present in the polity. It has to seriously consider how decisions may affect people of various backgrounds. So in the debate of establishing universal health care, the opinions of not only the potential taxpayers but also the poor have to be considered, since they will all be affected by such project. Instead of simply taking the opinion of the majority and the privileged as the final word, an inclusive process tries to make sure that the minority's voices are also heard and the merit of those opinions are considered.

Implied in this idea of inclusion is the liberal egalitarian idea that people should be treated as equals. Rawls' (1971) principle of equal liberty and opportunity, for example, requires that no one can deny another person an equal chance to participate in the political forum because of various morally arbitrary factors, such as economic and social position. Dworkin's (1977) idea that each citizen has a right to equal concern and respect in the political decision about how various decisions are made, including how goods and opportunities are distributed, argues for a similar point. His idea of equal concern and respect demands that no one be treated unequally on the ground that "some citizens are entitled to more [goods and opportunities] because they are worthy of more concern" (p. 273.). In this way, the inclusion criterion can be seen as an effort to ensure that people in different economic and social positions all have an equal chance to voice their concerns and that they can all achieve equality of opportunity in the deliberative process.

One way to ensure or promote inclusion is to encourage members of various minority and vulnerable groups to participate in the decision process. When members of these different groups that will all be affected by the policies are included in the decision-making body, they have a real chance to deliberate with those from other social groups and learn about each other's experiences and concerns. In making health-care allocation decisions, an inclusive approach helps ensure that not only the interests of the majority groups are represented. Rather, the concerns of minority groups will also be included.[105] By giving the minority and perhaps underprivileged groups an equal voice, we have a greater chance of ensuring that the majority and the powerful groups cannot maintain ignorance of the voices of the vulnerable groups.

It is sometimes assumed that a representative government that employs elected officials to speak for the people is inclusive. For example, it seems that representatives of various population groups can reveal to each other the respective concerns of these groups, so that the interests of all these people are included in the democratic process. In this way, the decisions made by elected officials are supposedly fair to people of different groups. However, the political process that I propose does not rely solely on representatives. Rather, it is intended to include citizens themselves as much as possible. In fact, I want to challenge the legitimacy of a decision-making process that depends entirely on representatives. After all, one may question how "representative" these elected officials may be, and whether they really portray an accurate picture of people's concerns. For example, under representative governments, even elected officials may only "represent" a very selective group of individuals, namely, their voters. Despite popular slogans such as "I will represnet all of you, including those who did not vote for me," it seems likely that the interests of those who did not cast their votes or voted for someone else may not be fully represented. Under this kind of representative government, the voices of the minority or the dissenters will probably never be heard or seriously considered in the decision process, and so the resulting policies may be unfair. In order to ensure that the interests of those who are not "represented" are also considered, an inclusive approach ought to allow individuals to engage in the decision-making process.

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[105] Young (1999) proposes a way of testing whether a political process is inclusive. She argues that if a public debate uses third-person language to refer to a social group, which rarely appears as a group to whom deliberators appeal, that social group "has almost certainly been excluded from deliberations" (p. 157).

2. Participation or Deliberation

What is important in addition to the first criterion of inclusion is the principle of public deliberation or participation, which I argue is the second criterion of a legitimate political process in a pluralistic state. This broad idea of deliberation is central to Gutmann and Thompson's (1996; 1999) theory of deliberative democracy.[106] After all, the principle of inclusion may not achieve very much if people are still treated as isolated individuals who make decisions on their own. For example, a survey that polls everyone living in a geographical area may include people from every background and is in that sense inclusive. However, the results of such poll may still be insignificant, since the respondents may lack information on these issues, or they still may not have thought about the matters carefully. They also may not have been given the chance to deliberate with each other their respective viewpoints, and so the poll does not help people to achieve a mutual understanding of each other's concerns or to establish social goals.[107] In other words, even inclusive polls do not help people form reflective understanding of their and others' respective interests. To give people an opportunity to form reflective understanding of various issues, citizens and officials need to get more informed about the issues behind such policies and discuss with each other their respective concerns. For example, public forums and open legislative sessions that invite people to participate in discussions and decision making can help fellow citizens think through the issues and understand each other's viewpoints that may not have occurred to them prior to the reflective or deliberative process.[108]

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[106] The notion of deliberative democracy is also discussed by other philosophers. For other discussions on this topic, see the collections compiled by Bohman and Rehg (1997), Macedo (1999), and Elkin and Soltan (1999).

[107] Recall that in the Oregon Plan telephone survey, people were asked to put themselves in the situation of a person with various conditions. The majority of the respondents, *who were able-bodied and had little knowledge of how others with such*

There are several features of this deliberative or participatory process that are worth noting. First, this participatory process is not simply one that encourages people to cast secret ballots and vote on various policies. As I mentioned, the majority under such a system can still repeatedly dominate the process such that the minority's concerns will never surface. Also, such a voting system still does not show why people vote in certain ways or give people a chance to engage in reflective discussion with each other. Many ballots only ask people to provide a "yes or no" answer, without asking the voters to explain their positions. In fact, secret ballots are designed to allow individuals to *not* expose or explain their decisions to others. In other words, we do not know if people have good or any reasons in supporting or rejecting certain policies. The deliberative or participatory process, on the other hand, requires that different population groups all participate with each other in deciding what policies can address their respective concerns and interests.

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conditions lived, simply said that they did not think that their lives would be worth living if they became disabled. Even if officials also polled those who actually lived with these conditions and see how they viewed their own experiences and qualities of life, these respective respondents might still not be aware of or understand each other's viewpoints, since they did not have the opportunity to actually discuss and deliberate with each other.

[108] Some "open legislative sessions," such as those in provincial legislature, allow citizens to be audience but not participants. They are not given the chance to speak in front of the officials. Other sessions may allow people to briefly present their viewpoints, but they still cannot vote on the issues being discussed at the session. The open legislative sessions I have in mind is a deliberative one. It not only allows people to discuss with each other and officials their opinions, but also to vote on various policies after the discussions.

Second, as I discussed earlier, the deliberative process is not only open for representative officials. Rather, members of the public are also invited and encouraged to participate in the deliberation and decision making. In fact, the main purpose of the deliberative process that I am proposing is to increase *public* awareness of various political issues and encourage participation at this level. After all, citizens are the ones that will be bound by the political decisions that result from the democratic process, and so they should have the opportunity to engage in the deliberative process and help shape the policies. Moreover, it is important that the citizens themselves become aware of what their and *other* fellow citizens' views are. Relying only on officials to "represent" the citizens' views does not provide much of an opportunity for citizens to understand their own position and the diverse interests of other citizens. I contend that when people are part of the deliberative process they will more likely feel that they are autonomous beings enacting laws for themselves. The decision-making process is not simply a top-down process with representatives making decisions and imposing them on the citizens. Rather, the citizens themselves are self-legislators, choosing policies that they believe will be fair to all. Whenever possible, citizens should deliberate with each other face to face or via various electronic media, such as teleconferencing.

Third, a participatory and deliberative approach is more than a mere "information and bargaining session." While the reflective citizens may initially think of the deliberative process as a place where they can try to convince others to grant their narrowly-defined or egoistic wishes, I argue that a deliberative process in which people have a chance to listen to each others' concerns can help reshape the parties' interests. This reshaping of people's interests marks one of the most important differences between the deliberative process and the libertarian's bargaining process.[109] While libertarians do not necessarily reject the value of communication among individuals, these individuals do not think of themselves as part of a social unit and do not try to form communal goals.[110] Their goal is simply to strike a deal that is beneficial for themselves and their loved ones. Individuals under the libertarian doctrine simply enter various bargaining sessions or join interest groups based on their pre-existing interests that may be narrowly-defined. They do not seem to be genuinely concerned with the interests of other moral strangers with whom they bargain. They do not seem to think that helping to fulfil their fellow citizens' interests is intrinsically valuable.

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[109] In a libertarian bargaining process, individuals try to see how the cooperative scheme may best advance their own interests. They do not see the scheme as something intrinsically valuable but a means to reach one's ends.

The deliberative process that I propose is different. It may be the case that people initially come together to promote their individual-based or group-based interests and to ensure that other individuals and groups do not misunderstand or ignore their pre-existing concerns. However, participating in such a process provides people the opportunity to not only raise their own concerns but also listen to others' interests. This process can change the way they see their relationship with others, and the meaning of self-interests. I argue that the conversation and deliberation among people can gradually lead people to think of their interests in a broader sense. They may now think of themselves as part of the community who value cooperation with their fellow citizens to carry out various projects or to implement certain policies that are advantageous to all. People are now attending to the matter not as separate individuals but as a social unit. They are no longer moral strangers who have no relation or attachment to each other. As Taylor (1989b) argues, when citizens participate in a common political entity and identify themselves as part of a polity, they start to think of the political institutions as an expression of themselves.[111] Such participation can help to create a bond among reflective citizens. It creates not a group that is reducible to separate individuals, but "us." In other words, the deliberative process would move gradually from being initially some sort of an information or even an individualist bargaining session to a cooperative deliberative scheme in which people try to find ways to come to overlapping consensus and promote their respective interests. Such ongoing group dialogues and interactior allow people to see their relations with people from other social groups differently and motivate them to be more in tune with their social spirit and move towards a more civic orientation in thinking of what policies are fair to all.

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[110] Those individuals may still have common or convergent goals. However, these goals are still individual-based.

[111] As we shall see in the next chapter, people may see mutual contribution to a tax-funded health-care scheme a project that promotes certain symbolic meaning, such as the value of cooperation to bring about a healthy population.

Fishkin's (1999) experiment points at the right direction. He believes that face-to-face deliberation is essential for people to reflect on various political issues. In his Deliberative Poll, a random sample of respondents are surveyed both before and after they have had a chance to discuss the issues together. This Deliberative Poll takes "a national random sample of the electorate and transports it from all over the country to a single place" (p. 282). It then immerses the sample in the issues with intensive face-to-face discussions. Fishkin points out that this poll is an attempt to encourage citizens to engage in the dialogue. He contends that without any motivation to engage people in public discussion, most citizens in the mass public do not spend much time or effort discussing public issues. The deliberative process, on the other hand, creates "an atmosphere of civic engagement and mutual respect in which every opportunity is provided for citizens to assess competing arguments, formulate their own key concerns on the issue in question, and have those concerns responded to by those who represent competing perspectives" (p. 283). After the participants have had a chance to work through the issues face to face, they are polled on various questions. The results are compared with the initial, baseline poll. Fishkin observes that people who vote on various issues after deliberation are not only more informed. They also arrive at more consistent positions and more consistent connections between their values and their policy preferences than people who are not given the chance to deliberate on such issues.

Although Fishkin's example involves a perfectly representative sample, he notes that "there is a difference between a sample of several hundred speaking for the nation and the entire citizenry actually speaking for itself" (Fishkin, 1995, 44). Even if the population probably would give us the same result if we ask them the same questions, "participation in the political process serves an independent legitimating function" (Fishkin, 1995, 44). It is "a form of connectedness to the system that expresses our collective political identity"

(Fishkin, 1995, 44). Fishkin believes that when we encourage civic dialogues, we can help to "create an engaged community" where people can "work together in a spirit of mutual sacrifice for public causes" (Fishkin, 1995,175).

In other words, part of the reason why an inclusive deliberative process is attractive is that it can motivate people to think about issues that they have never thought of before. It allows people to see different perspectives and why they may all be important. It is also appealing because it can encourage people to adopt a public spirit in trying to find ways to accommodate each others' interests or to find more shared interests. People who deliberate with each other as a group may feel connected to each other and the polity. Deliberation makes the policy-decision process "a matter for us," as Taylor (1989b) calls it. By talking about the concerns with each other, people are attending to the matters together as a group. Such activity is "not reducible to an aggregation of attendings-separately" (Taylor, 1989b, 167). The conversation that takes place is an irreducible common action, one that is *ours*. As Shklar (1991) also argues, people who participate in the political process receive an affirmation of belonging. They may from now on see their own self-interests in a different light and reflect on the issues from a broader perspective.

Allowing citizens to see for themselves the perspectives of others is another reason why having citizens themselves deliberate with each other is valuable. When representatives deliberate with each other and act on behalf on their voters, citizens may not feel that they are directly connected to others. They may also not feel that they are part of the decision-making process. After all, the representatives are the ones who learn about various issues, and they are the ones who make policy recommendations. When citizens themselves deliberate with each other, they gain direct knowledge of others' concerns and establish connection with their fellow citizens.

Knowing how their fellow citizens view the same issues, the deliberative parties' conception of what is in their interests may include not only how they themselves may achieve their own goals but also how their fellow citizens may achieve their respective goals. They may also start to think about themselves as part of a social community who want to accommodate others' needs and contribute to certain social goals. While the deliberative citizens may not all become unlimited or unconditional altruists, their perception of their relationship with each other will probably change in such a way that they will from now on consider others' perspectives as also important and as something which should not be ignored in their decision-making processes. Given the public spirit, they will probably be more willing to take others' concerns seriously and consider some kind of compromise with others reasonable or even desirable. They will likely be more ready to replace their selfish interests with broader sense of self-interests that incoporate communal goals as part of their interests.

3. Empowerment

A legitimate political process for a pluralistic state also has to ensure that the citizens have the necessary power to shape and challenge political decisions. Not only does the deliberative process need to include or consider the interests of various population groups, it also needs to ensure that such interests actually contribute to the final decisions or policies. For example, we may worry that even when citizens are being "consulted," their viewpoints are still being ignored because in the end the majority viewpoints still persistently dominate the decision process and resulting policies. In other words, without any active empowering measures to ensure that those in the minority groups can effectively change the dynamics of the deliberation process, the "participatory" process may still be able to exclude particular groups by ignoring the recommendations put forward by members of such groups.

The question is, how do we ensure that the planning process does not simply ignore the recommendation given by certain individuals and groups? Iris Marion Yong (1999) suggests that to truly address the concerns of various groups, we ought to give all potentially affected agents the opportunity to influence planning processes and outcomes. To say the least, we have to get rid of various discriminatory attitudes and barriers that may prevent those in minority groups from participating. For example, we may have to legislate "block voting" to prevent the powerful groups getting together and systemically outvoting those in vulnerable positions. We may also have to minimize various degrading attitudes towards those who may want to disagree with the majority. For example, "stereotypes about some who claim to speak, or prejudicial reactions to their persons or manner" may prevent their views from being taken seriously (Young, 1999, 156). I argue that these empowering measures are especially important when the social positions among the citizens are diverse and when certain policies may significantly affect the lives of minority groups. As I mentioned, some policies regarding health-care allocation, such as proposals to ration various primary-care services, have more impact on those who are poor and predisposed to certain illnesses. Given that these people are most vulnerable to such decisions, an inclusive deliberative process ought to ensure that the poor are given the real power to challenge the dominant groups and shape the decision process. As we shall see later, if the vulnerable group that may be significantly affected by such policies does not agree with these policies, the majority should not be allowed to simply go ahead and implement these policies. They have to explain to those in vulnerable positions why such policies should still be enacted when they further disadvantage them. If certain policies cannot adequately address the concern of the minority, the parties have to rethink the policy proposal and perhaps make certain compromises with each other. It is only when various groups that are most affected by such policies can all participate and challenge the decision process that we can build a health-care system that can actually correspond to the needs and interests of not only the majority but also other minority groups.

However, I want to distinguish ignoring a position from not adopting it. While I argue that representative members of various groups have to be consulted and that their viewpoints all have to be taken seriously, in the end it is inevitable that some viewpoints will not be adopted. After all, we can imagine that in a pluralistic state there may be some conflicting viewpoints such that it is impossible to consistently adopt all of them. It is possible that even after extensive deliberation, some people still hold a dissenting view. While there may be good reasons why the parties do not want to adopt a certain position or implement certain suggested policies, it is unjustified for them to simply ignore certain viewpoints.[112] To ensure that dissenting viewpoints are not simply being ignored, if certain deliberative citizens believe that such viewpoints should not be adopted, the burden is on them to explain to others how they have come to that decision of not adopting these recommendations. However, as we shall see later, once we have granted that the deliberative process gives fair consideration to all points of view, then even if some policies that are desired by some are not implemented, no injustice is done. One can still agree to the policies on the ground that they are formed in a legitimate political process that is fair to all. If one accepts the deliberative process as a legitimate one in determining what policies should be adopted, one has to also accept the decision that comes out of such fair process that gives all viewpoints equal consideration, even if the result is different from what one has hoped for.

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[112] Ronald Dworkin (1977) also argues that there is a difference between taking a particular perspective into account and adopting that policy. He says that people's right to equal concern and respect requires that those "who will be injured have a right that their

4. Reciprocity

The criterion of empowerment is closely linked to the fourth criterion for a legitimate deliberative process. The policies of a pluralistic state are legitimate only if they are acceptable to those who are affected by them. What this means is that various deliberative parties in the democratic state have to justify their positions and decisions by giving substantial moral principles that can be accepted by all appropriately motivated citizens who are bound by them. This principle of reciprocity, as Gutmann and Thompson (1996) call it, demands that citizens and officials aspire to a kind of political reasoning that is mutually acceptable or justifiable by each citizen in circumstances of equal advantage. As I have mentioned, citizen groups in a pluralistic state may have different concerns regarding various policies, and these policies may have different impact on various groups. While libertarians neither deal with the merit of various moral positions nor require their voters to explain to each other their respective viewpoints, I argue that a deliberative process is only legitimate if the reflective citizens are required to justify their decisions to each other. Such a requirement can also help ensure that people do not simply vote for various policies without having

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prospective loss be taken into account in deciding whether the general interest is served by the policy. They may not simply be ignored in that calculation" (p. 273). However, that does not imply that their interests have to prevail, since they "may nevertheless be outweighed by the interests of others who will gain from the policy" (p. 273).

reflected on the issues. As I mentioned, human beings as rational agents want each other to provide reasons for their actions and decisions. They also want to accept others' decisions and want others to accept their decisions on such bases. The reciprocity criterion echoes our desire to provide and demand reasons for decisions.

This reciprocity requirement is also an empowering mechanism to make sure that those who are in privileged positions and majority groups cannot simply impose their preferences and interests on those in less advantaged or minority groups. It demands that even powerful groups have to justify their viewpoints to the vulnerable groups. It ensures that those who are in advantaged positions do not have the licence to dominate the deliberative process and therefore the outcomes. In this way, various groups cannot simply make arbitrary or self-serving decisions that ignore the interests or violate the basic liberties of certain groups.[113] When policy recommendations have to be mutually acceptable before they will be implemented, the reflective parties who may have different pre-existing interests have to work together to find ways to reach compromises.

5. Publicity

The fifth criterion of a legitimate deliberative process, I argue, is the norm of publicity. For a deliberative process to be legitimate from the pluralistic perspectives, information on various issues related to the recommended policies, subsequent planning process, and the results of the process have to be publicly accessible. Information about what concerns were brought up by various population groups and how policy decisions are eventually reached should be available to the public. As Gutmann and Thompson (1996) argue, this includes the reasons that citizens and officials give to justify political actions and the information necessary to assess those reasons. The publicity principle is also an important empowering measure, since it allows the vulnerable groups to keep privileged groups in check. When these people's underlying interests are made public, there will be more public pressure on them to change their attitudes and interests or to publicly justify their self-serving and possibly oppressive interests.

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[113] Recall that this is one of the concerns that trouble libertarians and social constructionists. They are worried that powerful groups may dominate the process and impose on everyone else various policies that are self-serving and do not respect the rights and interests of the minority groups. As we shall see later, both libertarians and social constructionists can agree that the reciprocity requirement is essential to a legitimate deliberative process, since it helps to ensure that those in powerful positions cannot simply dominate the decision process and impose their viewpoints on everyone.

The publicity principle is also important because it provides another chance for everyone to evaluate the decision process and the results of the process. It allows citizens to know not only which concerns or interests are addressed and how they are addressed, but more importantly those that are *not* addressed by the final decisions and why they may be excluded. In this way, it ensures that no unintentional and intentional ignorance of some groups' concerns will go unnoticed. Such a requirement helps to constrain the actions of citizens and officials and motivates them to do their duty (Gutmann and Thompson, 1996). It also promotes awareness and encourages citizens to deliberate on and regularly review various public policies.[114] This can help reflective citizens to continually make informed decisions.

Objections to the Inclusive Deliberative Approach

One may question whether a deliberative approach as I have presented can actually achieve the goals I have suggested. For example, one may be skeptical that such an approach can really move people to care about their communities and fellow citizens such that they would not want to be egoists but would see themselves as part of a polity and work towards a social good. In this section, I want to present a few objections surrounding deliberative democracy and argue that when all the criteria as I have listed are present, a legitimate deliberative process can ease my opponents' worries.

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[114] Fishkin's (1999) Deliberative Poll may also shed some light on how the publicity criterion can help to motivate public interests. The first national test of the idea of such a poll was televised, which provided "an opportunity for the public to reframe the issues in terms that connect with ordinary people" (p. 285).

One of the criteria that causes concern is the criterion of inclusion. First, there is the complex issue of defining various groups and their representatives. Demands for inclusive representation for political purposes requires identification of various groups, which call for generalizations about shared identities. For example, various groups are often defined or categorized in terms of race, ethnicity, gender, class, sexual orientation, and so on. While such categorization allows legislators an 'easy' way to identify people, such generalization can be problematic, given that people may not 'neatly' fall into clearly defined groups.

The second problem of defining group membership is to determine who should have the authority to define such groups and how they may define them. If the majority is responsible for defining such groups, there may again be the worry that they are imposing an understanding of identity on people. As we have seen in the last chapter, categorization by the wrong people can be damaging for those who are being labelled. As Hacking (1999) points out, social constructionists worry about how categorization is often seen as something natural or inevitable, when such labelling is in fact historical and manmade. He claims that social constructionists often want to radically transform how the society categorizes people into various groups. In other words, in trying to identify groups and assign representatives in meeting the inclusion criterion, we may run the risk of labelling people in a damaging way.

While I agree that identification of group and group members is not a simple task, this does not imply that inclusion itself is the culprit. Moreover, it seems that one can still make identification without further disadvantaging various people who are already in vulnerable positions. One way to think of the issue of group identification is to acknowledge that the categorization that is used for the purpose of the inclusive deliberative process is *not* inevitable. The identification here in fact can be used to point out that the labelling is a social construct that may need to be changed or corrected over time. Without going into details, I contend that groups can be cautiously distinguished by their history and how the society has conventionally categorized them.[115] This identification process will probably be facilitated by public deliberation, when people voice their concerns about social stigma and how people of certain characteristics have been systemically excluded from participation. This process can help people realize how such labelling may have affected the social and economic positions of people of various backgrounds.

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[115] For a detailed analysis of the concept of the concept of a social group, see Iris Marion Young (1990).

Critics also worry about what the criteria of inclusion and empowerment entail. These criteria together demand that everyone, including those who are in disadvantaged positions, has the opportunity to participate in the deliberative process. These criteria ensure that those who are in powerful positions cannot dominate the decision-making process. However, not everyone is optimistic about the possibility of powerful groups being willing to participate on the same level with those who are in disadvantaged positions. Ian Shapiro (1999), for example, worries that economic and social differences may make it unlikely that people can deliberate with each other in good faith. He points out that very often different population groups are simply not in equal circumstances. Given the asymmetry, he is concerned that powerful players may try to shape the terms of public debate through the financial contributions they make available to politicians and political campaigns. They may be able to suppress some of what should have been the contending views, so that they are never discussed openly.[116] In other words, powerful citizens who have various underlying interests may simply not want to engage in fair deliberation with others.

I agree that power asymmetry *can* be a big problem in the pluralist state. However, it does not imply that an inclusive and empowering deliberative process is illegitimate. This asymmetry is problematic only if we allow it to shape the decision-making process. Certainly, in any non-socialist state, we have at least some disparity among people such that people are in different economic and social conditions. However, this does not imply that the disparity of conditions ought to translate into disparity in *political* power, such that certain groups can always dominate the decision-making process and exclude others. The deliberative state as I have proposed is designed to counter the possible problem of political domination. The concept of inclusion, which is based on the notion of equal respect and concern, demands that people not ignore the interests of the minority and vulnerable groups. Together with the criteria of inclusion and deliberation, the criteria of reciprocity and publicity can also help minimize the threat of power asymmetry in the political realm. Respect for people's right to equal basic liberties and opportunities requires that no one can legitimately be excluded from participation because of his or her social and economic status. It may also require that those in economically and socially privileged positions be restricted from using their positions to shape the deliberative process. For example, we may have to forbid the rich from buying television or radio time to "debate" various issues. In other words, in the deliberative process those who are in powerful positions cannot manipulate the deliberative process or refuse to cooperate with the vulnerable groups just because of their own underlying interests. After all, the policies enacted have to be mutually agreeable by all the parties involved, including those who are in less powerful positions. As Gutmann and Thompson (1999) reply to Shapiro, deliberation can reveal many underlying interests held by those in powerful positions such that these people have to publicly justify their interests to their fellow citizens, who would be bound by their interests. Those who are in powerful positions cannot simply refuse to cooperate with others in less advantaged positions.

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[116] Iris Marion Young (1999) also voices her concern that the rich may direct or dominate the political process to serve their interests and passively or actively ignore the voices of the poor and working people.

I also want to also argue that, when people all have a chance to deliberate with each other on various issues and work together to form mutually acceptable policies, they are more likely to think of themselves as part of a community and try to accommodate others' concerns. Certainly, they still have their self-interests in mind. However, when people work with each other as fellow citizens towards a shared goal, they form a community and are more likely to think of themselves as being bonded with each other by their shared pursuits. Their concept of self-interests will be more broadly based. As I argued earlier, their pre-existing idea of what is in their interests may be replaced by an expanded notion of incorporative interests. Their interests may now include not only what is good for them personally but also what is good for the community, the social entity. When one sees oneself as part of a community and not just a separate individual who establishes impersonal contracts with others, the good for the community constitutes part of one's conception of self interests. In this way, one may be more civic-oriented and willing to cooperate with others in the polity.

Putting aside the possibility of people being more civic oriented, one may argue that the principle of reciprocity by itself is problematic. Some have argued that this norm requires too much and possibly also rejects too much. On the one hand, it seems to require people to justify not only political viewpoints but also religious and personal standpoints (Galston, 1999). On the other hand, it implies that those claims that cannot or are not justified before any public bar can legitimately be considered "unreasonable" and thus excluded altogether (Fish, 1999).

Regarding the problem of justification, I do agree that certain things are not the state's business and so people should not have to justify some of their personal matters in public. After all, a pluralist society that recognizes the right to equal basic liberties would have to allow people to pursue their own concepts of a good life. If one's position does not lead one to infringe on others' right to the same liberty, one should not have to justify to others one's position. However, if one's viewpoint may lead one to vote for policies that may have significant impact on *others'* lives and well-being, it seems that there are good reasons why people should keep the dialogue going until they can come up with certain compromising policies. If one's personal or religious viewpoints directly affect one's stand and thus decision on various policies that have significant impact on others, it seems that such viewpoints cannot be considered a private matter anymore. The issue will become a political matter. This is especially so if one's decision may violate others' rights to basic liberties. Regardless of whether it is one's personal conviction or religious doctrine, a democratic process that recognizes people's right to equal concern and respect demands that one cannot without other important justifications take away other people's liberty. For example, if one's personal view may lead one to vote against domestic-violence legislation, then one has to justify his or her view to others. After all, this individual's standpoint and corresponding vote may take away the liberty of those being abused by their spouse. In this way, the person who objects to domestic-abuse legislation has to deliberate with others and justify to others his or her position.

Does the requirement of reciprocity violate the principle of democracy that I myself endorse? I argue that it does not. Democracy does not imply that we have to accept every viewpoint as equally valid. For example, it seems that the deliberative parties can or perhaps even should rule out those positions that are inconsistent with the democratic ideal. If certain people want the state to implement an "unequal health-care policy" that provides selective coverage based on people's ethnicity, it seems that those who will be disadvantaged by such policy are entitled to ask for justification for such policies. If justification for an otherwise discriminatory policy cannot be provided, this is a good reason why the deliberative parties may refuse to implement it.

Regarding the issue of exclusion, I do not imply that viewpoints that are not publicly justified and mutually agreed upon should be excluded from deliberation. After all, the deliberative process requires that reflective citizens have to first discuss these issues before deciding not to implement or adopt certain viewpoints. The process is also supposed to be an ongoing dialogue that encourages various parties to revisit policies and concerns. Consider J. S. Mill's (1859/1974) argument on the advantage of encouraging diversity of opinion and not excluding certain opinions that some deem to be unreasonable. As Mill says, sometimes the "nonconforming opinion is needed to supply the remainder of the truth of which the received doctrine embodies only a part" (p. 108). In this way, the deliberative process has to allow the possibility that those opinions that are not currently accepted by all can still have merits and thus ought not be excluded from the ongoing dialogue. However, if certain viewpoints do not fulfil the reciprocity requirement, it is legitimate for the deliberative parties to not adopt such positions after careful deliberation.[117]

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[117] Once again, recall that even Ronald Dworkin (1977) agrees that treating people with equal respect and concern does not require that we have to adopt all their viewpoints. Rather, we have to consider their merits. After careful consideration of the respective merits of all the positions, the deliberative parties can still make an "interim" judgement that certain viewpoints do not meet the reciprocity requirement and thus should not be accepted. However, this does not imply that the parties cannot revisit the issues again if they later

Another concern that may arise in dealing with the criterion of reciprocity is whether people in a liberal and pluralistic state can indeed come to any mutual agreement under this inclusive deliberative procedure. As I discussed earlier in this chapter, Engelhardt (1996) and other libertarians are often skeptical that people with different and perhaps conflicting moral visions can ever agree on various fundamental moral principles and issues. They worry that any chosen concept of the good is simply an arbitrary imposition on the part of the authority. In other words, it is unclear that any principle or viewpoint may fulfil the reciprocity requirement.

This skepticism is also shared by other opponents of deliberative democracy. Ian Shapiro (1999), who is skeptical about the possibility of minimizing power asymmetry in a deliberative state, also challenges Gutmann's and Thompson's (1996) optimism that deliberative processes may resolve all important differences. He argues that deliberation may not bring people together. In fact, it may reveal more irreconcilable differences and widen political divisions (Shapiro, 1999). In other words, one may still doubt that an inclusive deliberative process will lead to a decision process and resulting policies that are mutually acceptable to all that are bound by them.

However, as I argued earlier, we often *do* agree on important issues. Engelhardt (1996) and other libertarians sometimes argue that people in a pluralistic state do not or even cannot agree on goals. They concentrate on how we do not have a narrow conception of what constitute a good life that is accepted by all. However, I think that this focus is mistaken. While we may not agree on an objective and narrow account of the good life, we do have common experience of the bad (Galston, 1991; Hampshire, 1989). Many great evils of human experiences are shared by all and re-affirmed in every age. Human beings are constantly trying to find new or better ways to prevent or minimize such bad experiences. In other words, despite other differences, we can and do have some common ends in the sense that we at least have substantial consensus or agreement on what we want to avoid. Goals of

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believe that the positions previously not adopted may have more merits than they originally believed.

establishing universal health care, for example, are mainly based on our common experiences of various evils that we want to minimize or prevent.

Moreover, I argue that an inclusive deliberative process in a pluralistic liberal state can allow us a better chance to come to more agreement. Certainly, if we employ an individualist account of rights and contractual obligation, as often proposed by libertarians such as Engelhardt, we run the risk of not having any communal or social dialogue that can foster communication, understanding, trust, and mutual cooperation among citizens. Under the libertarian doctrine, people only concentrate on their rights and often ignore their responsibilities and obligations. They do not think of cooperative schemes and agreements as intrinsically valuable. They also do not think of themselves as part of a social community and see others as fellow citizens rather than separate and distinct moral strangers. Under the libertarian conception of individuals, it is certainly difficult for separate atoms to establish a sense of community that may underpin the willingness to cooperate with fellow citizens and to help those who are in disadvantaged positions. However, when citizens are given the opportunity to communicate with each other openly and see themselves as part of the community and related to each other, they have a higher chance of listening to each other's concerns and finding mutual grounds. They will likely realize that they all will be bound by the same agreements. As Gutmann and Thompson suggest (1999), it is "fruitful to keep open the possibility that underlying interests can change and that the deliberation that reveals them may contribute to such change" (p. 249). When people have a chance to reflect on various policies with each other, they will realize the impact of these policies on others both in privileged and disadvantaged positions, and may be more willing to give up part of their "competitive edge" to accommodate others' concerns. They may start to think that they have an obligation to each other to consider their interests. Even in cases where people reasonably disagree, the inclusive deliberative process can still be beneficial in providing standards for regulating the processes to help various parties to reach accommodating decisions or try to find better ways to resolve differences (Gutmann and Thompson, 1996, 73-4). And in cases where they simply cannot find any possible way to resolve their conflicts, the deliberative citizens who respect each other may agree to simply respect each other's pursuits.

So it seems that the inclusive deliberative approach as I have presented can ease the libertarians' and social constructionists' worry that welfare programs such as universal health care may be authoritarian measures imposed by the majority upon those whose voices are not heard. First, when people can participate in the planning process and express what they think would be the best means to fulfil their needs, they all have a better sense of what the issues are and what people may think are the best ways to deal with such issues. Second, when the minority groups are adequately represented and their interests are publicized, we have a better chance to keep the privileged groups in check. When people's interests and concerns are discussed openly and all minority groups are given the power to affect the deliberative outcomes, it is more difficult for the majority and the powerful to ignore or exclude their concerns and impose self-serving decisions. For example, in deciding what health-care services should be funded, inclusive deliberative processes will help to ensure that the resulting public scheme covers services that are not only important to the majority and privileged groups, but also to the minority and possibly more vulnerable groups. It is also more difficult for these groups to dominate or control the discussion processes. After all, they will have to publicly justify their decision processes and resulting policies to various population groups.

I disagree with some opponents of the deliberative process who seem to believe that those in powerful or privileged positions may not be willing to justify their viewpoints to others. I contend that while people want their proposals to be implemented, they probably also want them to be adopted not just because they can dominate the political process but because they are good proposals. For example, they probably want people to *agree* with them and think that they have good reasons to accept their arguments. In other words, when people deliberate with each other, they probably want to be able to justify their concerns to their fellow citizens.[118]

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[118] For example, people may feel embarrassed that they have to rely on their economic or social positions to "win" or get their way. They may want to show others that they can offer good reasons why others should agree with them.

The third reason why I think a deliberative process can ease the libertarians' and social constructionists' worries is that people in a pluralistic state are not only represented but also given the opportunity to share their concerns with each other. When people themselves have the chance to deliberate with each other, they have a better understanding of each other's experiences and can attempt to find some common ground or to seek reasons and principles that can be accepted by fellow citizens. Such understanding can help them reach agreements on what respective measures will address their health-care needs. As Gutmann and Thompson (1996) argue, deliberation that encourages people to seek fair terms of cooperation makes the result of such process mutually justifiable and binding. Such deliberation motivates people to think not only in terms of narrow or egoistic self-interests but move towards public spirit and try to find a solution that is beneficial to all.

Last but not least, libertarians and social constructionists can probably accept my proposed deliberative approach because this is a "self-legislating" process. Citizens themselves come to agree with a set of policies to which they will be bound. Moreover, such ongoing dialogues among people and public access to information regarding how decisions are made also allow citizens and public officials to revisit various issues and see if amendments to current policies are necessary.[119] Such an approach helps ensure that illegitimate policies will not be unnoticed. When people participate together to decide on various social policies, it is also more likely that the resulting decisions will truly fulfil everyone's needs and be mutually acceptable to all parties.

Now the question is, how would the deliberative parties decide on the issue of establishing tax-funded universal health care? When all parties that have particular concerns regarding health-care policies have a chance to deliberate with each other heir respective interests, how may they decide on what kind of a health-care system should be established? It is to these questions I shall turn in the next chapter.

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[119] Gutmann and Thompson (1996) suggest that we can encourage the habit of openness by creating more incentives for reconsidering important moral decisions and policies regularly, such as by lowering some of the existing barriers to fundamental changes.

CHAPTER FOUR

DELIBERATION ON TAX-FUNDED HEALTH CARE

In the last chapter, I argued that respect for people's liberty or autonomy demands that we have to take people's consent and dissent seriously in deciding what policies should be implemented. I also argued that an inclusive deliberative process that allows people to communicate and to deliberate with each other their respective concerns is the best way to solicit reflective opinions. In this chapter, I shall examine how reflective citizens in such a deliberative democratic state will decide on the issue of establishing tax-funded universal health care. I shall leave the question of what kinds of services should be provided by the tax-funded scheme to the next chapter. In this chapter, I shall concentrate on showing that reflective citizens in such a deliberate democratic state are likely to mutually agree to a tax-funded scheme that provides access to all. I shall also argue that, for those who may still refuse to contribute after deliberating with others, coercive contribution can be legitimate.

Goals of Establishing Tax-Funded Universal Health Care

Public opinion polls will not help in determining how the deliberative parties may decide whether they would like to establish tax-funded universal health care. After all, most societies operate from unreflective opinion of the "public," or perhaps more precisely, the majority. Even the Oregon Plan discussed in the last chapter, which was an attempt to employ "public values" to establish a minimal level of health care for those who need but cannot afford to purchase it, fell short of adopting a truly deliberative scheme as I have suggested.

What I am about to suggest also does not represent the other end of the spectrum. It is not intended to represent an *a priori* understanding of what recommendations *ought* to be implemented by the deliberative parties in a liberal pluralistic state. After all, a serious commitment to deliberative democracy does not allow anyone to single-handedly presuppose the outcome of such deliberation, i.e., what kinds of goals or recommendations will be adopted.[120] Rather, the following arguments represent what I predict would likely be adopted by people in a pluralistic state that employs a truly inclusive and well-functioning deliberative process in reaching political decisions. While I believe that reflective and deliberative citizens who take each other's viewpoints seriously and think as participants of a social community will likely agree with me, I accept the possibility that the recommendations and arguments adopted by such well-functioning deliberative process may differ from my suggestions.[121] This, however, does not imply that my proposal of using a deliberative approach to decide whether or not to collect taxes to fund a universal health-care scheme is flawed. Rather, it shows that a "one-person deliberation" does not tell us the whole story. Democratic deliberation has to include various social groups that engage in ongoing dialogues to ensure that the resulting decision is acceptable to all.

Deliberation on Tax-Funded Universal Health Care

In chapter two, I argued that basic health can be considered one of the needs common to every rational being regardless of one's specific life goals. Various health-care services that are necessary to restore or maintain health are thus very important. Without access to such services in time of need, we may suffer severe physical pain, become debilitated, or even die prematurely, which are some of the great evils that we all want to avoid.[122] Granting that we all share the same "evil-aversion," it is reasonable to assume that people who enter public deliberation will think about how they can best minimize or avoid such health-related evils.[123]

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[120] This is one of the arguments presented against Gutmann's and Thompson's theory of deliberative democracy. Stanley Fish (1999) and Iris Marion Young (1999) both worry about the extra-deliberative derivation of substantive constraints on deliberative outcomes suggested by Gutmann and Thompson.

[121] As I discussed in the last chapter, it is possible that some of the policies that pass the deliberative process and get implemented may not be certain people's first choice. However, so long as the deliberative process gives all competing viewpoints fair consideration, then even if some of the policies implemented differ from what one may prefer, so long as the policies do not violate one's basic liberties, one can and should accept the policy as being legitimate.

[122] I shall discuss the question of what kinds of health-care services the deliberative parties would want to fund in the next chapter. I shall argue there that reflective citizens will likely agree that services that are necessary to prevent premature deaths, relieve excessive

Rejection of Pure Market Approaches

Before entering the deliberative process, people may not have very much information regarding the impact of establishing universal health care. They may also lack information regarding how others view various issues. They may start thinking about the issues in terms of how such project may affect them personally. When they reflecting on the issues with others, the discussion may be more of an information and bargaining session for people to see what measures will best serve their own narrowly-defined concerns.

Regardless of this initial skepticism or uncertainty of what one may choose, people will still likely agree that access to health care is important because it helps everyone to achieve and maintain at least a minimum level of health and normal functioning. Given that everyone wants to avoid suffering from various severe illness and injuries, it is reasonable to assume that all reflective citizens want to have access to health-care services that are necessary to prevent or ameliorate such problems.[124] The concern is how these citizens would want to appropriate resources to finance such services.

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pain and suffering, restore normal species functioning and equal opportunity range, and prevent illnesses from happening, should be funded by a centralized scheme. For the sake of argument in this chapter, the phrases "essential health care," "basic health care," "essential services" and so on denote these health-care services.

[123] It is beyond the scope of this chapter to discuss how the deliberative parties may weigh health-related evils against other kinds of evils. This is also not to place to discuss how that weighing may affect the way people decide how much resources should be spent fighting health-related evils versus other kinds of evils, such as hunger and poverty. For the purpose of my arguments here, I simply start with the premise that people are averse to various health-related evils and see where they may go from there.

[124] What is built into my idea of "evil-aversion" is also the idea of "risk-aversion" as proposed by Rawls (1971). According to Rawls, in thinking about what institutions are just, rational persons will want to play safe and opt for a system that guarantees a satisfactory

First of all, we may consider whether the people would want to treat basic health care as a pure consumer good and rely solely on the private market to produce such services. For example, we can have private clinics and hospitals that provide various fees-based services. People who need various services may shop around to find the most affordable or best services. Under this market approach, each individual patient pays for his or her own services. If one gets sick or injured often, one will have to spend more on one's health care. However, if one is relatively healthy, one does not have to spend as much. Under this approach, individuals pay for themselves and do not subsidize each other's services.

There are at least two reasons why this pay-as-you-go system probably will not be mutually agreeable and thus will not be chosen by the deliberative parties. First, the people may worry about how income can affect one's access to various private health-care services. Second, an out-of-pocket system may not be "user-friendly" because "average patients" may have problems making informed decisions in such a market at the time of dire need.

Let us first look at the problem of how income may affect people's access to various essential health-care services. Granting that all rational beings are "evil-averse" and that suffering from various painful and debilitating conditions constitute great evils, reflective citizens would probably all want to have access to various essential health-care services that are necessary to minimize or eliminate such evils. However, when people reflect with each other on the structure and operation of the private market, they will realize that such a market does not guarantee access for everyone. Depending on one's income level, one may be able to afford some services but not others. We can imagine that those who are in the middle and lower income groups may not be able to afford various expensive but essential procedures that are necessary to save their lives or restore their functioning.

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minimum or the "maximin." Certainly, as many opponents of the maximin rule have argued, not everyone is risk-averse so that not everyone will choose the maximin rule. However, as we have seen in Gerald Dworkin's (1983) helmet example in the last chapter, one may respond by contending that those who allegedly are not risk-averse may simply be mistaken in their calculation of the risk factor.

Let us now turn to the second problem of the pay-as-you-go system, that is, patients may have problems making informed decisions in such a system. When people are in dire health-care needs, they are often vulnerable and cannot act as "intelligent consumers" in the health-care marketplace. The pure market, I argue, may not be in the interests of the "average patients." These patients usually do not have complete or even adequate information of their health conditions and various treatment options at the time they start to seek treatment. As one writer points out, we cannot assume that people can simply make rational decisions that aid their self-interest "in an area as complex, problematic and perilous as health care" (Rhoden, 1991, 221). There are variations in human capacity to understand the "product" to be consumed and those who have little or no understanding of such "product" may be in a disadvantaged position. In addition, "[c]onsumers in the health care marketplace often get little chance to shop around, comparing price, effectiveness, etc." (Rhoden, 1991, 220).[125] Very often they are acutely ill and anxious. Their judgement may also be affected by chronic mental or physical illness. They may therefore be more susceptible to exploitation. In this way, a fee-for service market will not be in their interests.

Given that the pay-as-you-go private market cannot effectively protect everyone from premature deaths, severe disabilities, and other health-related sufferings, reflective citizens who are averse to various health-related evils probably will not opt for such a scheme. Even if these parties think strictly in terms of self-interest, they will not likely agree to a scheme that does not guarantee protection from various bad experiences.[126] They will probably consider a second and perhaps more affordable possibility to fund various procedures, i.e., private health insurance. Under such a scheme, people pay insurance companies a premium that may cover a variety of health-care services. One may argue that while most people may not be able to directly pay for various expensive health services, they may still be able to purchase insurance, which is relatively affordable, to protect themselves.

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[125] Marmor (1991) echoes Rhoden's point and suggests that patients in many cases have "urgent needs and little information on which to base their decisions" (p. 25). Most of the time physicians simply use their professional discretion and make significant decisions on behalf of the patients.

[126] One may argue that the private market can be in the interest of those who are well off. I shall argue shortly that even people who are rich and can afford private health care have good reasons to reject a pay-as-you-go market.

Such insurance schemes may be what libertarians have in mind when they argue that people who are interested to protect themselves from various evils can join certain interest groups that can provide benefits that are only available through collective actions. While people may not be able to afford various expensive services out of pocket, they may join some collective schemes, such as an insurance company, which can coordinate cooperative effort and provide benefits for all its members or clients.

However, I want to argue that this "libertarian solution" will not work in the health-care scenario, partly because not everyone who is interested to join such collective scheme is *eligible* to do so. Whether an insurance program is affordable for one still mainly, if not completely, depends on one's economic status and health condition. In 1997, an estimated 43.4 million people in the U.S. were without health insurance coverage throughout the entire calendar year. Despite the Medicaid program, nearly one-third of all poor people had no health insurance whatsoever (U.S. Census Bureau, 1998). Moreover, another one-third of all indigent had inadequate insurance (Churchill, 1994). The situation has not improved since then. Such a high proportion of population remains underinsured and uninsured because the costs of these insurance schemes are still too expensive for the poor, who receive the fewest benefits and are in the poorest health (Churchill, 1994). We can also speculate that another important reason why private insurance programs cannot cover all individuals is that they set premiums and coverage restrictions on the basis of people's risk characteristics. Since insurance companies in the private market are profit oriented, many of them hesitate or even refuse to insure those patients who have various pre-existing conditions or family history of certain illnesses. They worry that these patients' conditions or their predisposition to have certain health problems will put them in a "high-risk" group. Even when these individuals may purchase insurance with some companies, it is not unusual for these companies to exclude coverage for certain essential but expensive procedures. This of course does not help those in poor economic and health statuses, since they probably cannot afford the excluded services in the private market if the need arises. We can foresee that the problem of risk-based insurance schemes will affect even more individuals in the future, given the increasing availability of genetic testing and that insurers would probably request the result of such testing in determining people's insurability. Such insurance-market approach will probably be rejected by reflective citizens because it puts those who are predisposed to certain illnesses at a disadvantage, given that private insurance companies may refuse to insure them or charge them much higher prices. It will also be rejected because the deliberative parties, who value autonomy, would want to protect people's right to keep their medical records confidential and not want insurance companies to look into the detailed medical history of anyone who wants to purchase insurance plans.

One may argue that we can regulate the insurance industry and only allow companies to obtain group-based information instead of individualized information. For example, we may allow insurance companies to only obtain statistical information on people in various professions or age groups but not specific personal information. Instead of finding out whether a particular insurance buyer has or is prone to various conditions, insurers may only find out whether people in certain professions are more accident prone, have more illnesses, or have higher hospitalization rates.

Let us put aside the issue of whether libertarians, who in general support *laissez-faire* economy, would allow the government or any centralized institution to control or regulate the insurance industry. Even if we assume that these regulations can protect people's privacy, they still may not avoid the problem of high premiums for people who hold "high-risk" professions or are in "high-risk" age groups. For example, people who work in coal mines or construction sites may find it difficult to get affordable insurance coverage. Unless their employers provide insurance coverage, these high-risk professionals may be put in a severely disadvantaged position, since they may not be able to minimize their suffering, prevent premature death, or regain their opportunity ranges or functioning if they become sick or injured.

Risk-based policies may also disadvantage the elderly, who usually require more medical services but also have less income. This is certainly problematic, since these people who are most in need of affordable health care may not have access to various essential services. This risk-based policy can have significant effect on everyone, since everyone will potentially get old and need such care. If we want to ensure that we will have health-care coverage when we get old, we probably will not opt for a risk-based insurance scheme that may deny us coverage in our golden years. In this way, even for those who are currently young, they still have good reasons to think about the long-term effect of risk-based scheme and reject it.[127]

Certainly, libertarians may suggest that people who worry about their eligibility for risk-based insurance schemes may consider adopting a different insurance scheme. For example, they may want to adopt an insurance plan that does not rely on risk assessment but charges everyone the same premium. Such a scheme evens out all the risk factors and does not charge people different rates because of their risk factors. While this scheme may benefit some people who are in high-risk groups or need regular medical attention, it may still be unaffordable for most people. After all, knowing that some people need extensive medical services and may have expensive claims, the insurance companies in the private and profit-oriented market will have to charge everyone an enormous amount to cover such expensive claims.[128] So even for people who are relatively healthy and do not have significant claims, they may still have to pay an expensive amount for their insurance coverage. When these people realize that their expensive premiums are used to subsidize those who are more dependent on the insurance plan, they may decide to pay for their own services out of pocket and not purchase insurance plans. After all, if people join such plans only because they want to pay less for their services, then they have no reason to keep contributing when they can get more affordable health care on their own effort. In the end, without the "low-claim customers" to offset the high-claim ones, the invisible-hand mechanism may lead the insurance companies to increase the premiums for coverage, and once again those who are most in need of affordable health-care plans may not have access to various essential services.

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[127] Under a risk-based scheme, those who are currently young may also create a financial burden on them because they may have to pay for their elderly relatives' medical bills.

[128] The fact that such schemes are profit-oriented implies that what people have to pay under such schemes will probably be higher than a tax-funded and non-profit scheme.

Churchill (1994) suggests that even those who currently have insurance coverage should rethink about the security of the insurance market. He argues that it is a mistake for one to assume that availability of health insurance means assured access to services in the long run. Observing the situation in the United States, he says that few people can be confident that their access to affordable care is invulnerable to sudden change. Not only are insurers always devising new ways to avoid the sick,[129] hospitals are also employing ways to avoid unprofitable patients. Those who are currently insured have little assurance that they will not at some point join the other millions who are uninsured or underinsured. The problem is that human beings are vulnerable to various foreseeable[130] and unforeseeable external forces, such as injuries and illnesses. Given that these forces can affect anyone, but that individuals who are in dire health-care need may have no access to essential services in the private market, it is reasonable to assume that the deliberative parties who are evil-averse and risk-averse will not opt for a pure private system. Even if at this point they only think about their own egoistic interests and are not concerned with others' needs, it seems that it is still against their narrowly-defined self interests for people to wish for either the out-of-pocket payment scheme and private insurance scheme. After all, neither of these payment methods provides guaranteed access to essential care. A preference for either one of these schemes conflicts with every individual's rational end of securing the conditions necessary for the satisfaction of his basic needs and other specific goals. If they do not have access to various essential medical services, they may have to suffer from pain, lose their functioning and opportunity range, and be put in a disadvantaged position.

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[129] Churchill (1994) points out that there have been cases in which persons diagnosed with HIV have experienced substantial reductions in the maximum health insurance coverage, which decreased from $1 million to $10,000.

[130] I shall discuss the implications of foreseeable injuries and illnesses in terms of responsibility in the next chapter.

Gerald Dworkin's (1983) discussion of irrational choices can shed some light here. If people are concerned with securing the conditions necessary for their goals, then it would be irrational for them to prefer anything that may threaten the achievement of such goals. Applying this argument to the health-care scenario, it seems irrational for people to adopt private insurance schemes that may threaten their ability to protect such conditions.

With this in mind, it seems that even if the deliberative parties initially think about access to health care only for themselves and their loved ones, they have good reasons to reject the pure private market and opt for a non-profit oriented universal health-care scheme that can help ensure that no one suffers from various illnesses and injuries because of certain arbitrary factor, i.e., disadvantaged economic position. In the next section, I shall argue that even a redistributive scheme that provides health-care access not only to the rich but also those who cannot afford to contribute can benefit the rich.

Tax-Funded Health Care and the Rich

One may argue that while the private system does not serve the interests of those in disadvantaged positions, it does serve the interests of those who are economically advantaged or healthy. In other words, these people will not prefer to redistribute their resources to finance a tax-funded universal health-care scheme. Under the compulsory scheme, the rich may be subsidizing the poor, and the healthy are probably subsidizing the sick.[131] In other words, their contributions may be higher than their expected health-care costs, and so redistribution does not benefit them but helps others. It is therefore questionable that tax-funded basic health care is in their rational self-interest.

However, one should bear in mind that it is difficult, if not impossible, to make clear demarcation among various groups. Certainly, it seems easy to distinguish the rich from the poor.[132] However, individual efforts among the rich may still only produce small-scale benefits. It may not be sufficient to support various costly but essential health-care services in the profit-oriented market, so the rich still have the risk of not having access to some essential procedures and treatments. Granting that people are "evil-averse" and "risk-averse" and that failures to gain access to various essential services may lead to one's premature death or failure to restore functioning or control pain and suffering, even those who are relatively well-off may reject the private system. It seems to be in their interest to opt for a non-profit system that coordinates universal effort rather than small-scale contribution.

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[131] Recall that those who are relatively healthy will probably reject an insurance scheme that charges a uniform insurance rate, since those who are healthy will be subsidizing others who are sick and accident-prone. They may reject the tax-funded system for the same reason.

Regarding the question of whether a tax-funded system is in the interest of the healthy, let me once again point out the effect of genetic testing on distinguishing the healthy from the "potentially sick." It is also likely that even healthy individuals will at some point fall victim to minor or major accidents and therefore will require various services. So it seems that non-profit universal health care can still be in the best interests of these rational agents.[133] As long as the amount of tax to be incurred to finance such services is not so high that the well-off and the healthy would not have adequate private resources left to pursue their own interests, they may be willing to pay for tax-funded health care despite its extra costs.[134]

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[132] One may argue that the possibility of unemployment and the instability of financial markets may also drastically change the financial well-being of the currently well-off. In this way, there is no guarantee that the rich will stay rich.

[133] Notice that one may be able to say that such a scheme is in the interest of all rational people even if they somehow do not choose it. Recall Gerald Dworkin's (1983) discussion on how people may irrationally ignore the possibility of getting severely injured from accidents when they do not wear seatbelts and helmets even when they are interested in protecting their physical integrity. We may also say that those who ignore the chance of falling victim to accidents and injuries and would rather pay more for out-of-pocket services when they actually fall victims of such conditions are making an irrational decision.

[134] Interestingly, a libertarian himself, Hayek (1978) does not take the extreme view. He thinks that taxation necessarily violates individuals' autonomy. If the necessity of paying a certain amount in taxes is known in advance, one can use that information as a basis of one's plan and thus can still follow a general plan of life of one's own making.

Some may argue that while it may be in the interests of the rich but (potentially) sick to support tax-funded health care, it is unclear that the rich who have no pre-existing conditions or do not work in high-risk professions also benefit from the tax-funded scheme. After all, given that they are in low-risk groups, they may either purchase relatively cheap insurance packages in the risk-based private market or pay out of pocket in a market that charges uniform rates to cover their *own* health-care costs. If they are required to contribute to finance universal health care, they probably have to pay more to cover the costs of health care for those who are sick and potentially sick. Redistributing their resources to finance tax-funded health care therefore may not be cost-effective for such individuals, and so some people may find such a scheme against their self-interests.

However, it seems that tax-funded universal health care can be beneficial to all if we rethink how the temporal element may affect one's dependence on various health-care services. As I argued earlier, people who are currently young and healthy may want to rethink their positions in the long run.[135] Certainly, those who are *currently* in low-risk groups may think that the out-of-pocket system or various insurance schemes are in their interests. They may rightly believe that at this point they can probably pay less for their own coverage than to contribute to a tax-funded scheme, which subsidizes those who are in high-risk groups. However, if we think in the long run, i.e., what people may prefer when they get older, it seems that everyone has good reasons to adopt a publicly-funded scheme that will provide one access to various essential services throughout one's lifetime. After all, even if I do not need extensive care right now, as a mortal being I would eventually get sick or injured when I grow older. At that time my health-care costs or insurance premiums may increase drastically such that I may not be able to afford various expensive services in the private market.

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[135] Menzel (1983) also argues that when we vote for a policy, we should not create the results that constitute the maximum value only from our current vantage point. If we know we will value the results differently later, we should vote for the policy that will maximize the value we will put on the events eventually. Applying this argument to decisions regarding health-care resource allocation, people should think about what they would need in the long run and not just what they may need at this point.

One may think of the tax-funded health-care scheme as a savings plan. A stable tax-funded scheme that continues over time allows people who have contributed through their lifetime to benefit from such contributions or savings. While those who are currently young and healthy may not use the health-care services provided by such a system frequently, it is likely that they will use the services regularly later in their lives. In this way, one may argue that the tax-funded health-care scheme is a mechanism that allows people to transfer resources "from one period in [their] lives to another," that is, "from one's youth to one's old age" (Daniels, 1985, 91; 92). A tax-funded health-care scheme can thus be considered a "benefit package" that is used to meet people's needs and preferences over their lifetime.

What I have said so far only shows how tax-funded schemes directly benefit one in terms of their own access to various health-care services in the long run. However, most tax-funded schemes are redistributive, i.e., some of the money collected from taxpayers will go to benefit of those who cannot afford to contribute. One may question how this particular aspect of a tax-funded scheme may benefit the rich.

Without arguing in details, I contend that a redistributive scheme to finance universal health care may benefit the rich in indirect ways. For example, it is reasonable to assume that rich entrepreneurs, who hire numerous employees and target various consumer groups, all benefit from a healthy population. Productive workforce translates into efficiency in the workplace and high spending power in the market, both of which in turn imply profit for the entrepreneur and investors. If the workforce is in poor health and cannot afford to pay for various health-care services, we can imagine that entrepreneurs may "pay" for having an unproductive workforce. Economists can also tell us numerous ways that entrepreneurs and investors depend extensively on the market, i.e., how *others* behave. So even if tax-funded health care only directly improves the health status of others, it can still benefit the rich taxpayers who do not have any pre-existing conditions or predispositions to develop certain illnesses.

The benefit that rich taxpayers enjoy from a healthy population also goes outside the "profit circle." In particular, the rich benefit greatly because a tax-funded universal health-care scheme is the best, if not the only, way to stop communicable and possibly fatal disease from spreading. If people who are infected with various communicable diseases cannot afford to seek treatment, even the rich may be at risk. After all, even if the rich can purchase private health care to cover their own medical expenses, that by itself may not be sufficient to protect them from being infected with contagious diseases in the first place. Whether they are protected from such transmittable diseases partly or even mainly depends on whether others are infected. If others are infected and they come into contact with the rich (e.g., they may be employees who work for the rich), then the rich may get infected. Redistributing their resources to finance a universal health-care scheme thus can benefit the rich.[136]

The Transformative Deliberative Process

Besides the fact that tax-funded universal health care may in the long run benefit the rich personally and economically, it seems that tax-funded universal health care is against the rich people's best interests only if we accept a narrow conception of atomist self-interests. As we saw in the last chapter, libertarians do not seem to think that cooperative schemes are inherently valuable. They seem to assume that separate and distinct individuals will decide on their own whether various endeavours or policies are in their or their loved ones' interests and whether they would want to support them. However, it seems that these atomist individuals under the libertarian doctrine may only focus on how a particular cooperative scheme benefit them personally. They may not consider how their decisions may affect the well-being of others.[137] Such a notion of atomist individualism assumes that one's well-being is a personal and private issue that has no bearing on others. At the same time, this atomist notion also seems to assume that others' well being has no bearing on ourselves. However, I contend that such an understanding of well-being is flawed. Human beings are not isolated and independent from others. Rather, individuals' well-being is often affected by others' actions and non-actions, or perhaps even others' well-being.[138] Human beings are related to others by ties of recognition and concern in such a way that our identity is often other-entwined and other-identified (Nussbaum, 1995). Other-regarding actions can often negatively affect or enhance our own well-being.

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[136] This example only concentrates on the benefits of public-health programs. I shall argue shortly that even tax-funded non public-health services are in the interests of the rich if we take a more incorporative notion of self-interests.

[137] One may argue that libertarians are not committed to the idea that individuals have to be extreme egoists. They may still be limited altruists such that they still care about their loved ones. However, as I argued in the last chapter, these if these people hold firmly the motion of contractual obligation and believe that they have no obligation to help anyone unless they have voluntarily entered into an agreement, it is very unlikely that they will be altruistic towards these people.

The inclusive deliberative approach as I have proposed will inform reflective citizens how their actions may affect others' well being. It will bring people's attention to how they themselves may find the best ways to finance their health care. It will also inform people how certain vulnerable groups may not be able to get access to essential health care in the private market because of various morally arbitrary factors. While libertarians seem to think that we should leave it up to individuals to decide whether they want to join certain cooperative schemes (e.g., insurance plans) to finance their health care, I have argued that private health-care plans do not work that way. Many people who would want to purchase insurance plans may simply not be eligible to do so because of their economic and health factors.

By bringing people together in deciding what measures are best to ensure health-care access to all, the inclusive deliberative process will reveal how the private market cannot attend to everyone's needs. When people have the chance to deal with the issue of affordable health care with each other as a group, the deliberative approach can motivate people to think about their ties to others and consider the effects of their decisions on others. While initially people who engage in the deliberation may concentrate on gathering more information to see how various policies may benefit them personally, through the reflective deliberation with each other, people are likely to gain an understanding of each other's concerns. They may increasingly adopt a sense of fellowship or see themselves as part of a community. Since they have to justify their own positions to others, the deliberative approach requires people to reflect on and perhaps change their own positions when these positions are not accepted by others who may be affected by such positions. In other words, in trying to understand one's own interests and how that may relate to others' concerns, deliberative parties may start to see their standpoints as not only affecting how they may live but how others may live, since their corresponding decisions will be mutually binding. With a better sense of the how people's respective concerns may affect the outcomes that have a "larger effect," I argue that the deliberative parties will be more motivated to incorporate others-regarding concerns and communal interests as *complementary* or *part of,* and not against, their self-interests. By recognizing the importance of interdependence and reciprocity in people's lives, I argue that even the rich can benefit from tax-funded universal health care that can produce a healthy *population.*[139]

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[138] As Nussbaum (1995) points out, Aristotle also believes that human beings are by nature political beings partly in the sense that self-sufficiency is not a solitary but a communal self-sufficiency. He believes that our relations to other humans are constitutive of our identities as human beings. In other words, sociability thoroughly permeates our lives.

Certainly, one may argue that the rich who participate in the deliberative process may not consider others' well being as part of their concerns, if these people's well-being does not affect their own personal interests. One may also point out that other-regarding concerns and communal interests are sometimes at odds with individual self-interests, so it is naïve for me to assume that people in the deliberative process would ever agree to promote social interests over one's personal interests.

This objection, I argue, is plausible only if we adopt an atomist understanding of self-interests, since it portrays individuals as standing against everyone else in trying to secure their own private interests. In adopting a deliberative approach, it is unlikely that people will continue to be extreme egoists. As I argued in the last chapter, people do change their views after being more informed on various issues and having face-to-face discussions with other fellow citizens. They will also more likely treat the issues as "their" issues instead of simply matters being dealt with by separate individuals.

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[139] The phrase "healthy population" can be distinguished from "healthy individuals." While the latter still treats individuals as separate entities, the former recognizes the value of talking about a community.

In arguing that other-regarding concerns and communal interests can be consistent with one's self-interests, I do not pretend that these concerns are always the same thing. I agree that they can *sometimes* be conflicting. However, this by no means implies that others' and communal interests can never be consistent with one's own interests. For example, when the rich see communal interests as part of their own interests, they may want to establish tax-funded universal health care even if that does not directly improve their health status but that of the sick and the poor. Being part of the community and the deliberative unit, they may actually care about whether others in the community are suffering from various undeserved disadvantages. For example, they may start to consider allowing others to suffer because of various morally arbitrary factors when they themselves are enjoying various luxuries not only unsympathetic but shameful. In this way, even though the rich may have to contribute to improve the condition of those who are in dire needs, they may find the tax-funded health-care scheme acceptable.

Nozick's later works (1989, 1993) also shed some light on how people in the deliberative process may think of themselves more as team players rather than separate individuals who are egoistic utility maximizers. While in his early work (1974) he argues for an atomist libertarian position, in his later works (1989; 1993) he acknowledges the inadequacy of this account. As he admits, the individualist position does not "fully knit the humane considerations and joint cooperative activities" (Nozick, 1989, 287). His earlier account looks "solely at the purpose of government, not at its *meaning*; hence, it [takes] an unduly narrow view of purpose, too" (Nozick, 1989, 288; italics original). Nozick now realizes that the libertarian account neglects "the symbolic importance of an official political concern with issues or problems" (Nozick, 1989, 288). It ignores "the importance to us of joint and official serious symbolic statement and expression of our social ties and concern" (Nozick, 1993, 32). He now believes that how we think of our relationship with others is in part an "expressive concern" that should not be ignored (Nozick 1989, 287).

If we think about the way that the deliberative parties may think about establishing tax-funded universal health care, we can imagine that even the rich may start to think of themselves not as simply isolated individuals who only think about how such a scheme may affect them personally. They may start to see themselves as part of a unit and want to adopt a tax-funded scheme that may contribute to the welfare of their fellow citizens. The rich may start to see themselves as part of a larger community and think of contributing to others' welfare as part of their interests, such that paying a small portion of their resources towards such a program can incur symbolic utility for them. They may actually internalize the goal of minimizing undeserved disadvantages and want to contribute to such a cause.[140]

So far I have argued that it is likely that people in the inclusive deliberative process will eventually all care about universal access to essential health care and thus all have good reasons to consent to a tax-funded universal health-care system. Certainly, if everyone does agree to contribute to such a system after deliberating with others, libertarians would acknowledge the legitimacy of such program. However, some rich people may decide that the benefits they can get from such a system do not outweigh the costs. They may also not care about the well-being of the needy even after inclusive deliberation. In these cases, a libertarian may argue that they should not be coerced into paying for such program.

The Rich Dissenters

I argue that the public-good problem provides a justification for the deliberative parties to coerce the dissenters to fund universal health-care, which can be considered a public good. Given the high costs of various treatments and procedures, coverage for all requires (almost) unanimous contribution. However, once the scheme is available, it cannot effectively exclude non-contributors from benefiting from such a system. Even if we can find a way to refuse treating non-contributors for free, there are still other benefits that such non-contributors will enjoy. As I mentioned, the health of the population has enormous impact on the efficiency of the workforce and consumer behaviour. In cases of public-health measures, such programs can also affect the health of those who refuse to contribute. The fact that a rich free-riding individual cannot be excluded from enjoying the "spillover" benefit may lead to the collapse of such a system. The possibility of free riders may discourage those "reluctant cooperators" to contribute, since they are unwilling to allow themselves to be exploited by free riders (Arneson, 1982, 622-3). At the same time, without the assurance that enough people will contribute, the free-riders may also discourage the "nervous cooperators," who would otherwise pay their fair share if enough other persons also contribute to keep the scheme viable, to waste resources in support of a lost cause. In other words, when free riding is possible, in the end free-riders will discourage contribution from other reflective citizens who would otherwise contribute and thus universal health care cannot be established or maintained effectively.

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[140] Sugden (1993) also points out that people who think of themselves as a component of a team may want to do their part in achieving outcomes that are good for all. When all the deliberative parties, including the rich, think as a team, the morality of cooperation gives everyone good reason to follow the team's objective.

Libertarians may object to my argument by pointing out that, unlike security forces or certain public-health programs, universal health care should not be the state's business, since it is not an essential mechanism to prevent rights violations. Even if they acknowledge that universal health care may not be established in the private market, and so some people will have no access to various essential services, these issues are inadequate to support coercive taxation to finance universal health care.

I shall respond to some of the problems posed by the libertarian position shortly. The reason why libertarians claim that we should leave people alone even when that may result in market failure is that they believe that market failure is less of an evil than coercive redistribution. These anti-authoritarian theorists are suspicious of the state's use of coercive power to improve the welfare of its citizens and argue that the state should be minimal and remain neutral among various incommensurable concepts of the good life. Engelhardt (1996) and other libertarians argue that individuals should be the ones to decide how their lives should be run, including how they would like to dispose of their resources. They argue that people should be allowed to decide what projects they want or do not want to pursue, regardless of how others may feel about the value or morality of their projects. They believe that if the state coerces unwilling individuals to redistribute their resources to improve the welfare of others, they are arbitrarily adopting a certain concept of the good and illegitimately imposing it on autonomous individuals. These theorists believe that, in the area of secular morals, there is no rational basis to choose among various conceptions of the good. We do not have access to moral truths, so any decision on what constitutes a good life is bound to consist of the imposition of someone's authority on others. As Engelhardt (1996) says, "much of what structures the concrete fabric of everyday moral lifeworld" is simply arbitrary and conventional (p. 37). He argues that any attempts to justify tax-funded universal health care or any other welfare programs will inevitably fail, since appeals to any particular moral content beg the question of the standards by which the content is selected. The unavailability of objective knowledge of the good and the fact that reasonable people may disagree on the concepts of the good life, Engelhardt argues, mandate mutual respect among individuals and "hands-off" policies. When citizens reasonably disagree, the state has to stay neutral and allow its citizens to act on the basis of their own morality and life goals. He argues that coercive redistribution to finance any welfare programs, including universal health care, thus cannot be justified. Attempts to make the rich help others are seen as authoritarian measures to impose certain arbitrary concepts of the good on these individuals or to use them as mere means to fulfil others' ends.

However, we should keep in mind that, contrary to what libertarians claim, tax-funded welfare programs are not pushing individuals to adopt certain conceptions of the good. Rather, granting that people are all "evil-averse," welfare programs including universal health care are directed at ensuring that no one has to suffer from various illnesses and injuries because of morally arbitrary factors such that they can achieve their own conceptions of the good.[141] Ongoing deliberation with each other can help us to determine how programs should be run, and what services should be funded. Even if such deliberation cannot always resolve conflicts, it can at least help us find reasonable compromises and identify the better ways to consolidate basic opportunities for everyone. We also have to keep in mind that universal health-care programs, for example, are not mandatory-treatment programs.[142] They are rather directed at ensuring that citizens have access to the necessary services that will allow them to avoid some great evils and gain or regain opportunities to pursue their own life goals. The existence of such programs does not mandate people to use these services, if that clashes with their own goals. As Plant *et al* (1980) point out, welfare policies aim at fulfilling everyone's various needs so far as this is possible, but it is still up to individuals to decide whether to take advantage of these programs. As I shall argue in chapter six, measures to finance universal health care also does not imply that individuals may not purchase their own services elsewhere, such as in the private market.

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[141] It is interesting to note that some libertarians, such as Hayek (1978), argue along the same line. Unlike some extreme libertarians, Hayek agrees that compulsory taxation to finance health care to help the needy is justifiable. He claims that the use of coercion by government "to secure the best conditions under which the individual may give his activities a coherent, rational pattern" is consistent with the idea of freedom (p. 144).

A Right to Do Wrong? The Social Good and Fairness Arguments

So the question is why libertarians still insist that the rich should not be taxed to help these needy individuals when there is overwhelming agreement regarding what constitute bad experiences. There are a few possible reasons for such insistence. For example, libertarians may argue that individual freedom is the highest value of all, so much so that we should tolerate immoral actions and inactions, as long as they do not directly violate others' rights. While minimizing individual suffering is perhaps an admirable social goal, it should be a goal for volunteers to achieve. Saying that such a goal is admirable does not imply that it is legitimate for the government to tax unwilling individuals to achieve such a goal, since doing so violates their autonomy and property rights. Even if we assume that individuals have a moral obligation to help the needy, it is up to the individual to act upon this obligation. Others simply have no authority to force the individual to adopt group spirit and act virtuously or to accept a duty of benevolence. In fact, to put it in a Kantian way, an action can only be considered virtuous if it is acted out voluntarily by an individual who willingly accepts this responsibility from the motive of duty. If one still does not want to contribute after deliberating with other fellow citizens, one should be allowed to withhold contribution.

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[142] However, in certain public-health cases, treatments may be mandatory for those who are infected with communicable diseases, since people with such diseases may pose great harm to others.

I have already challenged the validity of the atomist notion of individuals. I want to argue that the deliberative parties will likely also reject the libertarian response for the following reasons. First of all, while the deliberative parties do take the requirement of reciprocity seriously, they may mutually decide that it is too extreme to say that coercing participation from unwilling individuals to reach certain important social goals is never justifiable. There are perhaps some projects that are so important to everyone in the society that they warrant coercive contribution to establish and maintain such projects. In fact, even most libertarians do not deny that helping the needy is a legitimate and worthy goal. This is important, because social schemes to achieve such a goal do not violate the libertarians' moral visions, since we are not forcing them to support something they do not already believe in.[143] I do not deny that such schemes do to a limited degree restrict the self-determination of the tax payers. However, it is unclear that even minimal limitation is never justifiable. Extreme libertarians are not just arguing against radical egalitarian conceptions of welfare programs. They seem to think that even minimal taxation is unjustified. After all, even charging people 0.0001% of their salaries through taxation would still be coercive (Beauchamp, 1991). However, it seems that "no reasonable theory of morals would hold that liberty is an absolute value, above life and above all forms of welfare" (Beauchamp, 1991, 77). In fact, even Hayek (1978), who is a libertarian, suggests that so long as the benefits are worth the cost, the desirability of governmental provision of certain services can hardly be questioned. For example, most sanitary and health services, and perhaps many of the amenities provided by municipalities for the residents, are highly advantageous to society. Such services are essential in promoting the health of the population, which also provide other spillover benefits. However, given that these benefits are non-exclusive public goods, the private market would not be able to produce and maintain them effectively. Even though such services are not necessary to prevent coercion among individuals or protect individual rights, Hayek (1978) admits that the government may legitimately finance such projects with tax dollars. In other words, it is implausible to maintain that taking a limited amount of resources from citizens to prevent a serious evil or to achieve an important social goal is never permissible. As Nagel (1981) says, there is no reason to think that the force of property right is absolute or nearly absolute, i.e., never capable of being overridden by consequential considerations. Limited restriction on the use of property is a minimal limitation and is justifiable in some cases.[144]

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[143] Also, one may argue that some individuals may vote against tax-funded schemes even though that is in their interests. For example, these individuals may have irrationally placed other values over the value of health protection from a reliable and affordable scheme. In this way, one may argue that coercive taxation does not violate the person's self interest. While it may be a paternalistic policy, it is consistent with the person's own self interest.

Another problem with the libertarian response lies in its assumption that people should be free to decide whether they want to accept the social goal of minimizing undeserved disadvantages. As I explained in chapter three, the libertarian notion of contractual obligation seems to allow people to decide whether they have any enforceable obligations. If one happens to disagree with such a goal, one should not have to contribute to help those who are in such disadvantaged positions. In fact, even if one has no other reason but simply does not "feel like" contributing, one's refusal to enter an agreement provides one an absolute immunity. The inclusive deliberative approach that I have proposed does not agree with such an extreme notion. Its reciprocity requirement demands that people who refuse to cooperate publicly justify to others why they do not think that cooperation is legitimate. This public deliberation can probably reveal the underlying interests of those who are in privileged positions and thus do not want to support such a principle. As I have argued before, those who are in powerful positions probably cannot justify to those in disadvantaged positions that they should remain in such positions, since that denies the latter's right to equal opportunity range.

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[144] Judith Jarvis Thomson (1977) also argues that it is sometimes acceptable for us to infringe people's property rights. For example, if the only way that we can save a child's life is by breaking into your medicine cabinet and giving the child some medicine, we can legitimately do so. This is the case *even* if you refuse to consent. Your property is "'overridden' by the fact that the child will die if we do not go ahead" (p. 50). Judith Jarvis Thomson believes that while our acting against your will infringes on your rights, it does not violate them.

The public-goods argument provides another reason why it is legitimate to coerce the rich dissenters to contribute to the tax-funded scheme. Even if there are problems in coercing people to be morally good or caring, the principle of fairness demands that people have an obligation to contribute regardless of whether they care about the welfare of others or not. As I mentioned, while universal health care requires redistribution, it benefits *everyone* by either providing access to various essential services or by providing one with various significant spillover benefits. So in addition to the aforementioned self-interest and social-good arguments, I suggest that we can use the principle of fairness in justifying taxation to finance universal health care. The significance of such benefits makes it reasonable to assume that every "evil-averse" and self-interested person would like to enjoy such benefits. Given the benefit that each individual may *willingly* enjoy from universal health care, and that it is unfeasible to attract voluntary compliance to the scheme if people are not required to participate, it is justified for other contributors to employ minimal coercion as needed to secure compliance from others. The principle of fairness demands that people should not gain from cooperative efforts of others without doing their fair share. Given that universal health care cannot exclude anyone from significant benefits that are probably welcomed by every rational agent, the fairness principle demands that each person has to do his or her part.[145] If one *voluntarily accepts* the benefits of the arrangement or takes advantage of the opportunities it offers to further one's interests, one has an obligation to pay one's fair share. This is not an obligation in a weaker sense, i.e., one should have the freedom to not fulfil such obligation. What we are dealing with is not a matter of individual's private and imperfect duty of benevolence. Rather, once an individual voluntarily accepts benefit produced by the joint efforts of others, benefit that cannot be produced otherwise, one's obligation to contribute becomes "public" and enforceable. Although such a demand does limit the freedom of the benefactors, it does not do so illegitimately.

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[145] For a detail analysis of the principle of fairness, see Rawls (1971). In the next chapter, I shall also discuss how this principle may take into account one's responsibility in causing various health conditions one suffers, and how that may affect one's eligibility to publicly-funded services.

Libertarians may argue that we cannot "just act so as to give people benefits and then demand (or seize) payment" (Nozick, 1974, 95). I do agree that not all benefits are appropriately regulated by the principle of fairness. For example, there may be cases where the benefits are minimal to justify imposition of coercion, or that the benefits are intended to be gifts bestowed upon the recipients. There may also be other cases where there are good reasons or evidence to show that the recipients do not wish to receive the "benefits," or that it is easy to exclude non-contributors from receiving benefits, or that voluntary contribution may be sufficient to finance the program. However, in the case of universal health care, there are good reasons to assume that every rational agent would be happy to receive the direct and spillover benefits such that enforcing payment from the benefactors can be justified.[146]

In this chapter, I have argued that tax-funded health care is in everyone's interest, and that the deliberative parties have good reason to support establishment of such a health-care system. I have also argued that, even if some people are reluctant to contribute after deliberating with each other, the fact that universal health-care is a public good that is voluntarily enjoyed by all provides a fairness argument to support compulsory contribution to support such program. The question now is what kind of services the deliberative parties would want provided in a publicly-funded system. It is to this question I shall turn in the next chapter.

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[146] In examining whether the rich are voluntarily accepting the spillover effects, we may ask whether those entrepreneurs who are enjoying the benefits of having a healthy workforce would want to move to another location if the population health started to deteriorate drastically. If their answer is yes, then we may say that they are voluntarily accepting the spillover benefits of a healthy workforce and thus are required to contribute under the fairness argument.

CHAPTER FIVE

WHAT SHOULD WE FUND?

In the last chapter, I argued that the deliberative parties in a democratic state will agree to a tax-funded health-care scheme. Now the question is, what kinds of services should be funded in such a society? In this chapter, I shall argue that the inclusive deliberative process can once again guide us in determining what services are reasonable to include in a universal health plan in a democratic state. I shall argue that, given some background understanding of a democratic society and people's common goals to avoid and minimize various health-related evils, reflective citizens in a deliberative democratic state will likely agree that a decent level of services necessary to prevent premature deaths, restore functioning and equal opportunity, prevent various diseases and injuries, and care for those suffering from excessive pain, should be provided by the government scheme. Finally, I shall argue that, given that every insurance plan has coverage limits, the deliberative parties still need to consider which of the services that can achieve the aforementioned goals may be funded, and who should receive such services. I shall argue that scarcity may lead people in the deliberative democratic state to employ a cost-efficiency approach and the concept of responsibility to guide them in resolving allocation dilemmas.

Determining the "Decent Minimal Level"

One question that may arise is, once the deliberative parties in a democratic state have decided that tax-funded health care is warranted, do they still need to reflect together in deciding what kinds of services should be provided? If we have already established that deliberative parties in the democratic state would want to establish tax-funded health care to ensure a healthy population and that no one suffers from undeserved disadvantages, does that not suffice in guiding them in making allocation decisions?

Norman Daniels, who in the late 1970s thought that we could simply employ an extended version of Rawls' fair equality of opportunity principle in allocating health-care resources, later became convinced that general principles of justice are too indeterminate to resolve key rationing issues (Daniels, 1999). For example, the fair equality of opportunity principle by itself does not tell us how much priority we should give to helping the sickest patients, or how much weight to give to uses of scarce resources that produce best medical outcomes. Daniels argues that to resolve disputes regarding health-care resource allocation, we need a deliberative model of fair procedures.

I agree with Daniels that a deliberative approach is necessary in making resource allocation decisions in a pluralistic state. Besides the possibility that general principles of justice are too vague and too broad to provide guidance in dealing with specific disputes regarding allocation, I want to suggest other reasons why a deliberative approach is essential.

As I mentioned in the last two chapters, health-care allocation policies affect various groups in different ways. The establishment of a tax-funded system can drastically improve the health status of those who are economically disadvantaged and cannot afford private health care. It can also improve the condition of those who have various pre-existing conditions or are predisposed to such conditions. Specific decisions regarding what kinds of services should be provided under the tax-funded scheme also have different implications for different population groups. For example, decisions regarding whether various primary-care services should be covered have more health-related impact on those who are poor than those in economically privileged positions.[147] Policies regarding home care, on the other hand, in general affect the elderly more than the rest of the population. To ensure that the policies fairly and adequately address various groups' concerns and thus would not systemically disadvantage certain groups, deliberative parties need to discuss with each other and reflect on various concerns of respective population groups in making allocation policies. For example, given that the availability of primary care can greatly improve the condition of those who are economically disadvantaged, those who do not support funding such services need to publicly justify to the poor why they do not think that these services should be or are worth being funded. The reciprocity requirement discussed in the last chapter demands that the decisions regarding what services should be funded have to be mutually justifiable or agreeable to the deliberative parties.

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[147] I specify health-related effects here because the poor are not the only ones affected in general; the rich are affected in monetary terms.

In thinking about what kinds of health-care services should be covered by the tax-funded scheme, I argue that deliberative parties would start their decision process by discussing with each other their mutual goals of establishing universal health care. As I mentioned in previous chapters, welfare programs are established to prevent people from being disadvantaged by various bad experiences. In thinking about what kinds of services should be covered, deliberative parties would thus concentrate on various kinds of bad experiences they all would like to avoid.

As we shall see shortly, "public preferences" as shown by opinion polls in most developed societies differ from what I believe the deliberative parties will likely adopt.[148] Discussions of health-care reform concentrate on how we can fund more high-technology and expensive acute-care treatments that are necessary to restore people's functioning and prevent premature deaths. However, I shall argue that this focus is flawed. While acute-care medicine is *one* of the focuses of establishing tax-funded health care, given that resources are scarce, deliberative parties who have a clear understanding of what medicine can and cannot do will probably want to balance funding rescue medicine with other health-care services.

My analysis of what reflective citizens would likely want to be covered by the tax-funded plan is partly based on what people all seem to want to avoid in life and partly based on what people in a democratic state specifically desire. The four types of health-care services that I believe the deliberative parties would give highest priorities are services that are necessary to prevent premature deaths, restore functioning and opportunity range, prevent diseases and injuries from happening, and ameliorate health-related pain and suffering. The first two categories on the list, i.e., prevent premature deaths and restore functioning, are usually the foci of public opinion polls and allocation discussions. However, I shall argue that while these goals are important, the deliberative parties in a democratic state will likely want to balance them and possibly even give more emphasis to preventive measures and services that are necessary to minimize severe pain and suffering. While my analysis may be controversial because it differs from the results of opinion polls, this variation does not imply that the deliberative process is flawed. In fact, given that most societies do *not* employ an inclusive deliberative approach in making allocation decisions, deviation between my recommendation and the empirical results is expected.

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[148] I want to once again bring attention to the possibility that opinion polls as employed in most societies do not truly reflect people's preferences, since some people may cast their votes without having reflected on the issues.

I. Prevention of Premature Deaths

Contemporary medicine has been focussing on how various medical procedures can cure or treat patients who may otherwise die prematurely. Public opinion polls also show that people seem to want more funding to be put in hospitals to increase the number of acute-care beds and in research to find cures for various possibly fatal diseases. These opinions seem to be "on the right track," since people usually consider premature deaths as one of the greatest evils, if not *the* greatest evil. Although as mortal beings death will come to all mortal beings, untimely or premature deaths are often seen as something bad or unfortunate.

While people across cultures in general agree that premature deaths are bad and should be avoided if possible, what constitutes "premature" deaths may be socially relative. As Callahan *et al* (1999) point out, the notion of "premature" death is not universal, but rather relative to history, culture, and the state of available medical technology.[149] In general, death is considered premature when an individual "dies before having an opportunity to experience the main possibilities of a characteristically human life cycle" (Callahan *et al*, 1999, 28), such as the chance to pursue and gain knowledge, to enter and establish close relationships with others, and to develop one's capacity for personal flourishing.[150] While people who live a 'normal life span' in general all go through these stages, what counts as a 'characteristic' human life cycle or the length of 'normal' life cycle may differ depending on the history and technology available. Whether one's death is premature can be determined by comparing the person's life span or life cycle to others in one's society. If one's life is short relative to others in one's society, and one has not had a chance to go through various stages and opportunities that are usually experienced or enjoyed by others in that society, one's death can be considered premature.

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[149] So perhaps one can say that the concept of premature death cannot be discovered in the natural world but is constructed by the society.

[150] In a recent article, Callahan (2000) reiterates the claim that a premature death can be understood as a death that occurs before a person has lived long enough to experience the typical range of human possibilities and aspirations. These possibilities include working,

There are good reasons why the deliberative parties would probably want the government to fund services that are necessary to prevent premature deaths. Putting aside the general consensus that premature deaths are great evils, people in a democratic state probably are also concerned about lost opportunities. Death deprives the dead of their possibilities, capacities, and opportunities they would have (Momeyer, 1988). People in a democratic state, who care about autonomy and the importance of people's opportunities not being curtailed by others and various morally arbitrary factors such as ill health, will likely also want to ensure that people do not die prematurely.

Our eagerness to prevent premature deaths can be seen in various breakthroughs in health care. Medical researchers try relentlessly to find new and better ways to conquer various diseases and injuries that may take our lives. The resulting technological advances have been credited for preventing numerous premature deaths by restoring the patients' health. In the last few decades, sanitation and various public health measures have helped prevent people from being infected with various deadly diseases. At the same time, antibiotics, heart surgeries, chemotherapies, organ transplants, and so on have been used frequently in developed countries to restore the health of seriously-ill patients who otherwise would have died from various potentially fatal illnesses. Such services have given many people "a second chance" to life and have helped to expand people's normal life span. Granting that people in a democratic state care about autonomy and the evil of undeserved

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learning, procreating, seeing one's children grow up, and so on.

disadvantages, they would consider how health-care resources can be used to prevent premature deaths.

While I agree the deliberative parties would likely want to fund a decent range of services that are necessary to prevent premature deaths, we need to realize that not all deaths are premature and unacceptable. After all, we are mortal beings and death will eventually come to all. While endless progress in modern medicine seems to have encouraged the idea that all deaths are premature, or that deaths at any particular time are accidental and not inevitable, perhaps we need to rethink such impractical expectations and embrace the fact that we *are* mortal beings. Even though it may be an acceptable personal goal to try and extend life, we need to consider the costs and sometimes difficulties of achieving significant additional gains through technological innovation (Callahan *et al,* 1999). As mortal beings who face scarce resources, the deliberative parties will likely realize that it is unreasonable to try to eliminate or indefinitely postpone death at all costs or the expense of other important health and social needs.[151] As Callahan *et al* (1999) point out, the struggle against death "should always remain in a healthy tension with medicine's duty to accept death as the destiny of all human beings" (p. 27). We also have to bear in mind that such invasive methods to extend lives may not always provide significant benefits. For example, in cases where the patients are terminally ill and have already lost their capacities for various activities, invasive life-extending interventions may not help the patients to enjoy various activities. In fact, in some of these cases, extending lives by various invasive methods may inflict more pain and suffering on the patients, which violates the principle of non-maleficence. As we shall see later, inflicting or extending patients' pain and suffering is against one of the common goals of establishing tax-funded health-care goals, i.e., to alleviate excessive pain and suffering. When the deliberative parties have a chance to think through what medicine can and cannot do, they may realize the importance of accepting the conflict between preservation of life and pursuit of a peaceful death. As Callahan (2000) points out, the acceptance of the fact that deaths are not accidental and sometimes acceptable can help people to put more focus on improving palliative care and find other ways to improve the quality of life within a finite life span.

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[151] Certainly, we can always put more money into acute-care medicine either by charging more taxes or by cutting services in other sectors, such as education and housing. However, the parties will have to balance the importance of these other services and respect for people's autonomy. They will therefore have to rethink how much tax they can charge to provide "death-postponing" services.

II. Restoration of Normal Species Functioning and Opportunity Range

Besides premature deaths, there also seems to be general agreement that we want to avoid having our normal species functioning and opportunity being restricted. This goal is especially important in a democratic state, which respects and promotes people's autonomy by encouraging them to participate in public deliberation that shape the political decisions that govern all in the polity. Such a society will also likely care about how morally arbitrary factors may affect people's fair equality of opportunity. In this way, the deliberative parties will likely want the government to fund those health-care services that are necessary to prevent people's opportunity range from being diminished because of various illnesses and injuries.

Liberals' arguments echo my reasoning. They in general argue that it is a matter of justice that the state should correct disadvantages caused by undeserved factors. Rawls (1971), for example, argues that a just liberal state ought to minimize undeserved disadvantages that may restrict people's fair opportunity range. According to him, the importance of the principle of equal opportunity lies in its attempt to minimize the disparity between the upper and lower classes in both means of life and the rights and privileges of organizational authority. Equality of opportunity allows everyone the chance to gain access to public offices and positions. It demands that nobody is excluded from experiencing the realization of self that comes from a skilful and devoted exercise of social duties and various external rewards of office such as wealth and privilege. Daniels (1985), who applies this principle to health-care resource allocation, argues that medical resources ought to be distributed in such a way that they promote equality of opportunity by restoring people's normal species functioning. He argues that health-care needs are unique in that they relate to our ability to function as normal members of our biological species. When this ability is impaired, we cannot enjoy the normal opportunity range for our society. Daniels argues that people who suffer from various impairments are therefore unfairly restricted from leading an autonomous life or pursuing various life goals that may be possible for others in the society. According to him, the government-funded health care scheme ought to include various services that are necessary to restore one's normal functioning and equality of opportunity.

An example can show how the principle of equality of opportunity may support the argument that health-care services that are essential to restore people's normal species functioning should be funded. Suppose a woman becomes quadriplegic after a severe car accident and thus now has a very restricted activity range. She may need extensive help for daily activities, such as getting in and out of bed, getting around her own home, and so on. She may experience even more difficulties in public places, especially if they are not equipped for ramps, automatic doors, and so on. Given her mobility restrictions, she may also be exposed to more dangerous situations. For example, if there is a fire or she is in some other kind of hazardous situation, she will likely experience extreme difficulties in quickly getting herself to safety.

It seems that this person's impairment may also have important political implication, since it may result in her losing equality of opportunity. In this woman's situation, she may find it difficult to get a job that can accommodate her needs, given that employers are unlikely to spend a lot of money to match one employee's conditions. In this way, she may have difficulty improving her social and economic positions, and thus her opportunity range is unfairly limited because of the injury, which is a morally arbitrary factor. Worrying how such undeserved disadvantage may affect people's opportunity to participate as fully functioning citizens, deliberative parties are likely to agree that health-care services to help the patient regain her functioning should be funded.[152]

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[152] Deliberative parties are likely to think of political participation as one of the most important aspects of citizenship. After all, inclusion and participation are two of the criteria of a legitimate decision-making process. If some people cannot participate because of various arbitrary factors, the decisions that come out of the deliberation will be

While I do agree that restoring people's functioning and their opportunity ranges is important in a democratic state, I argue that the deliberative parties will likely reconsider whether medical or health-care services are always the best means to do so.[153] While many concentrate on the government's duty to provide various medical services to restore such opportunity ranges, I argue that the deliberative parties will likely realize that sometimes providing health-care services may not be the best way to protect people's opportunity range in the long run. The reflective deliberation among citizens will likely inform people that in some situations the most effective means to correct and prevent unfair disadvantages is by changing the society's attitude towards people who live with various conditions. As we discussed in chapter two, the experiences of people who live with certain impairments are often determined by the way that society deals with such conditions and its attitude towards people who have these conditions. An impairment or a condition by itself may not disable a person who lives with such impairment. Whether one is disabled often depends not only on the biological or medical factors but also social factors. The Martha Vineyard's example discussed earlier, in which some people on the island were deaf but were not being disadvantaged by their condition, shows that sometimes the best 'cure' for disability is not health-care services but social education. What is worth noting in that example is that those who were deaf did not sustain or regain their opportunity range by seeking medical help to correct their hearing problem. Rather, the communal environment was 'friendly' to those who could not hear and thus did not disadvantage such individuals. Because people who were not deaf knew sign language, they could communicate effectively with those who could not hear, so that both groups could interact with each other "normally." Those who were not deaf also treated people with hearing problems as equals, and therefore the latter did not feel that they were the outcast or that their opportunity range was significantly diminished

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unrepresentative.

[153] For example, even though Daniels (2000) realizes that sometimes people's disadvantages are "socially correctable," he wants to use health care to correct both "natural and some socially induced disadvantages" (p. 315).

because of their impairment. In this way, even though people who were deaf had an impairment, they did not lose their fair opportunity range.

In other words, the deliberative parties who care about people's opportunity range and equal participation have to find out the best means to restore people's opportunity range. Although medical services are in some cases the most effective way to ensure that people who have certain conditions do not suffer from unfair disadvantage, in other cases social education may be the better means to correct such disadvantage.

While I agree that restoring people's functioning and opportunity ranges are important goals of establishing universal health care, there are two concerns that the deliberative parties may have to address. First, there are certain debilitating conditions that can be prevented. Second, there are times when people's functioning simply cannot be restored. These concerns, as we shall see shortly, remind us that the deliberative parties will probably have to balance the goals of restoring normal functioning with those of preventing illnesses and injuries, and ameliorating pain and suffering. Given that resources are scarce and that medicine cannot always restore people's functions or that there are better ways to prevent people from losing their normal functions, the deliberative parties have good reasons to rethink the relative priority of the goal of restoring functioning.

III. Prevention of Diseases and Injuries

Menzel (1983) points out that health-care expenditures today go for the medical treatment of health problems after they have arisen. If newspaper articles and allocation policies are indications of how people think about the relative importance of different kinds of health-care services, it seems that people in developed countries are more willing to pay for rescuing few individuals from serious accidents or illnesses than to pay for various preventive programs that can avoid such problems befalling more individuals. Heated debates regarding health-care resource allocation in developed countries often focus on how we can put more resources into rescue medicine. In evaluating the performance of health-care systems, people often look at the length of waiting lists for surgeries, availability of high-tech equipment, and so on. As one Canadian journalist reports, hospitals are "the largest and often most emotionally resonant symbols of a community's access to health" (Sass, 2000a). Debates in Canada, including the 2000 premiers' conference, focus on how we can open more hospital beds or buy more expensive equipment. Newspaper headlines are flooded with concerns about acute-care availability (Sass, 2000b).[154] In developed countries such as Canada and the United States, billions of dollars are spent on developing rescue or curative medicine each year. Talks of health-care reforms also focus on how we can buy more expensive diagnostic machines, expand coverage to include various new high-technology treatments, open more hospital beds, or expand intensive-care units. In other words, discussions and debates regarding health-care resource allocations often concentrate on how we can or should deal with people after they have got sick or injured. While there are increasing interests in preventive measures that can help people to avoid getting sick and educational programs to teach people how to prevent getting injured in the first place, these programs are still being overshadowed by curative programs and research in treatments.[155] For example, even at the last international AIDS conference, public interest focussed on clinical trials of the newest treatments and cutting prices on the AIDS-suppressing drugs. While efforts were made to reiterate the importance of prevention, in the end the spotlights were still on the issue of treatment.

The relative emphasis on treatment is also seen in the arguments of various philosophers. Norman Daniels (1985), as we have seen, concentrates his discussion on *restoring* normal species functioning. He explicitly says that health-care resources should be allocated with restoration in mind but is relatively quiet on the issue of prevention. It is often assumed that the focus of health care is on correction and thus should focus on the sick and not the healthy.

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[154] Sass (2000b) refers to the headlines in Calgary's newspapers during January 1999, which reported frail seniors being sent home from hospital, patients lying on emergency-room floor, ambulances being diverted from one hospital to another, all because there were not enough beds in the city.

[155] As we shall see later in this chapter, whether such preventive measures are available have an impact on how we may think of the legitimacy of using responsibility as a criterion in allocating scarce health-care resources.

While Daniels (1985) and others concentrate their discussions on *restoring* normal species functioning, I argue that *maintaining* such functioning and *preventing* it from deteriorating are also important. So after careful deliberation, people who engage in democratic reflection with each other would probably put more emphasis on prevention. If part of the goal of establishing universal health care is to ensure that people do not have to suffer from various illnesses and injuries, it seems that prevention programs are likely to be welcomed by all reflective and deliberative parties in the democratic state. Although there is still limited knowledge of causal links, there is evidence that in general preventive measures have beneficial social and economic consequences by reducing the extent and burden of morbidity and chronic disease later in life (Callahan *et al*, 1999). Studies have shown that in the long run heroic measures are not the only or even the most effective means to prevent pain, disabilities, or premature deaths.[156] In other words, preventive measures may be more effective in helping people avoid having to suffer in the first place. One writer reminds us that cures for cancer, heart diseases, fallopian tube disease, and so on are "partial, problematic, or very expensive," but such conditions are often preventable (Menzel, 1983, 152). Prevention therefore seems to be a better alternative not only medically but also financially. Deliberative parties who work with limited resources and try to get the most for their health-care dollar are therefore likely to advocate increased emphasis on prevention.

The question is, what kinds of preventive measures would the deliberative parties agree upon? I argue that reflective citizens would want to make sure that immunization programs to stop communicable and possibly fatal diseases from spreading are available under the tax-funded scheme. There are a few reasons why such programs are important.

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[156] However, one may argue that prevention can be costly in the long run. If people live longer as a result of good prevention programs, in the end they will depend on the health-care system for longer. For the purpose of this chapter, I shall put aside this concern. After all, it seems that deliberative parties have good reason to opt for longer and healthier lives.

First, as I argued in the last chapter, the private market is ineffective in protecting people from being infected by various communicable diseases. Even if I can purchase private health care to cover my medical expenses, that by itself may not be sufficient to protect me from being infected with contagious diseases in the first place. Whether I am protected from such transmittable diseases partly or even mainly depends on whether *others* are infected. If others are infected and they come into contact with me, I have a much higher chance of being infected. The problem with controlling such diseases with the private market is that, if individuals are responsible for the costs of such treatments, those who are economically disadvantaged would not be able to seek help. If these individuals are infected, without proper treatments their infectious diseases would likely spread around and pose severe threats to themselves and to others. If the deliberative parties worry about premature deaths and losing functioning because of various health conditions, they would likely want immunization programs to be covered under the tax-funded scheme to ensure that everyone is protected from various severe diseases.[157]

Deliberative parties who are concerned with the overall costs of various health-care services will also likely agree that preventive measures that have high cost-effectiveness ratios but cannot be provided by the competitive private market should be funded. Immunization programs are not the only means to prevent contagious diseases from spreading. Sanitary services are also extremely important. The drastic decrease of epidemics and longer life expectancy in developed countries during the last century are not the results of various acute-care services but mostly the results of better sanitation. Clean water and good sewage systems have been credited for preventing various possibly deadly diseases from endangering people's lives. However, it is extremely difficult or perhaps even impossible for the private market to provide such services efficiently, since sanitation is a public good and cannot exclude non-payers from enjoying the benefit. Given the problem of free-riders, the private market may have difficulty in obtaining voluntary payment to establish such important services, although anyone who cares about his or her health would want to have sanitary services available. The deliberative parties in the liberal state are thus likely to agree that sanitation services should be funded by the government scheme.[158]

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[157] In fact, the deliberative parties are likely to agree to mandatory treatment or immunization in cases where the diseases are highly contagious and can pose severe threat to the community.

Besides various medical procedures or services, other *social* programs are also important to prevent various diseases and injuries from occurring and are likely to be supported by the deliberative parties in making allocation decisions. Educational programs, for example, are very important for people to understand various origins of diseases and injuries and can help prevent people from getting sick or injured. Such programs are especially important when causal links are first discovered between various conditions and behaviours since most people are not medical experts and may not be aware of such causal links. Programs on preventing AIDS, for example, have educated people on how such deadly viruses are transmitted. They have also taught people how they can protect themselves from contracting such disease. Educational programs on cancer, which provide the public information regarding links between nicotine and lung diseases or alcohol and liver diseases, have warned the public the danger of long-term exposure to such substances. Campaigns teaching people how they can prevent getting severely injured by wearing helmets and seatbelts have also helped people to avoid catastrophic injuries. Without such educational programs, people may not know how to protect themselves from getting sick or injured in the first place, and may thus have to suffer from various conditions. The deliberative parties, who want to protect themselves from premature deaths and losing functioning, would therefore likely want to fund such services that can help people to prevent getting ill or injured. As we shall see later in this chapter, the availability of such educational programs may provide an argument to give certain people who do not follow the advice lower priority in receiving treatment.

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[158] One may question whether sanitation should be considered a health-care measure. However, it seems that we can put aside the demarcation issue here. The important point is that the deliberative parties would want to fund sanitary services. Whether they are considered health care or not is secondary.

The aforementioned programs can also help to ensure that people do not have to lose their opportunity range and thus autonomy. While rescue medicine tries to restore people's functioning, prevention tries to avoid people losing their opportunity ranges in the first place. The fact that prevention of disease and injury may be even more effective and cost-efficient in preventing lost of opportunity and premature deaths in a population implies that the deliberative parties need to balance curative and preventive measures in making allocation policies.

IV. Relieving Excessive and Prolonged Pain and Suffering

As I mentioned earlier, contemporary medicine often focuses on treatments that may restore people's health. What accompanies the focus on restoration seems to be a myth that as long as we can find cures and treatments to restore people's normal functioning and thus their health and autonomy, there is no need to worry about care or pain relief. As Callahan *et al* (1999) point out, physicians do not always understand or practise the palliation of pain. They often also lack understanding of patients' mental and emotional suffering that can accompany illness and injury. When there is good knowledge of effective pharmacological approaches to pain relief, physicians often depend upon the drug to do the work that more properly requires counselling and empathy. There is a tendency for physicians to take the patient as a collection of organs rather than a whole person that requires holistic care. It is also interesting to note that discussions of health-care reform rarely focus on allocating more resources for pain relief.

I argue that the deliberative parties that reflect on the potentials and limits of what medicine can and cannot do would likely put more emphasis on relief of excessive pain and suffering. Moreover, if we redirect our focus on people's evil-aversion, it seems that the deliberative parties have good reasons to fund pain-management programs. Even though we may not agree on a narrow conception of what constitutes a good life, there is general agreement that excessive and prolonged pain and suffering are some of the greatest evils and should be avoided. Advocates of various forms of euthanasia and assisted suicide, for example, try to justify their position by linking such procedures with terminating excessive pain. Even opponents of euthanasia and assisted suicide agree that pain and suffering should be avoided or minimized, although they believe that other measures are perhaps morally preferable. Effective pain-management programs can also achieve the same goal.

What is interesting about the euthanasia debate is that both proponents and opponents of euthanasia can agree that pain management is an important goal. In a pluralistic state, people do not always agree on the morality of various issues. However, while the deliberative parties may not mutually agree on the morality of euthanasia, they can probably all agree on funding pain-management programs. For the opponents of euthanasia, the availability of such program is justified or even essential because it can minimize the number of requests for euthanasia and assisted suicide. The proponents of euthanasia, whose main concern is to provide comfort by relieving patients suffering and pain, probably will also welcome pain-management programs that can help reduce the patients' suffering.

This agreeability of the importance of pain-relief programs makes our contemporary tendency to overlook pain and suffering even more odd. Perhaps the potentiality of contemporary medicine is one of the reasons why people sometimes forget the importance of pain relief. As medical technology advances, there are many health conditions that could not be corrected in the past can now be treated. Various aggressive procedures have been used to not only prevent premature deaths but also to restore the functioning of patients. Such success has not only invited the unrealistic thought that death can almost always be delayed; it has also encouraged the idea that we can restore functioning if we try hard enough. In the end, deterioration of condition is sometimes seen as failure of the health-care team or *current* medical technologies rather than an inevitable and perhaps acceptable result of human mortality. Employing pain-relief measures, especially on terminally-ill patients, may be seen as failure of medicine rather than another way of caring for patients.

Another reason why relief of pain and suffering are often ignored in the health-care profession is perhaps because it is difficult to diagnose pain inter-subjectively. While X-rays and other diagnostic measures can show us whether a patient has got a certain disease or an injury, there are not any inter-subjective ways to accurately measure pain and suffering that do not depend on individuals' own report or behaviour. We often have to rely on the patients' own words or their behaviours to determine whether they are in pain or suffering.[159] There are also cases where health-care providers may have trouble diagnosing the cause of the pain and thus do not know what may be the most effective means to treat it. In other words, pain and its management may be puzzling cases that people do not know how to treat.

While there may be disagreement on the cause of pain, we in general agree that pain and suffering are great evils that should be prevented or alleviated. Nobody wants his or her life to be full of pain, even if such pain is not associated with severe illnesses or may lead to the patient's premature death. In this way, even when medical technologies may eventually restore our health, the deliberative parties probably would not want to overlook the importance of their role in relieving patients' pain and suffering.

The role of pain relief is also important from a historical point of view. As some have argued, the relief of pain and suffering caused by maladies[160] is perhaps one of the most traditional goals of health care (Callahan *et al,* 1999). It is not until the last century that various medical advances can offer hope to cure or treat various maladies. For centuries before that, the medical focus was on minimizing the pain caused by such conditions. Although in recent decades the focus of health care has shifted from relief of pain to high-tech and acute-care procedures, pain relief is still essential. After all, there are still numerous maladies that cannot be or may never be prevented, treated, or cured. Moreover, given that we are mortal beings, at some point in our lives our bodies will simply no longer respond to preventive or curative treatments. In the worst situations, the patients' conditions may start or continue to deteriorate, and increasing pain may also accompany such changes in conditions.

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[159] This may be a reason why funding for pain-management programs may be difficult. If we have to rely on the patients' report in determining whether they are in pain, then it is conceivable that some patients may want to exaggerate their pain to get funded treatment.

[160] Malady describes the circumstances in which a person is suffering or has an increased chance of suffering from an evil (e.g., premature death, pain, severe disabilities, etc.) that is caused by an impairment, injury, or defect (Callahan *et al*, 1999, 20).

These are some troubling scenarios, because it seems that there is nothing more that health-care providers can do to stop the patient's conditions from deteriorating. A patient in such situation is perhaps most vulnerable. However, this does not imply that the patient's well-being is unimportant once treatments are deemed futile to restore his functioning or prevent death. It also does not imply that the government should not provide funded health care for the patient. Certainly, curative medicine may be futile in the sense that it cannot restore the person's activity range or extend the patient's life. However, pain-relief measures can control the patient's pain and suffering from reaching an intolerable level. In fact, this may be the only relief for such patients. In those cases where the patient's death is imminent, pain relief can provide much-needed comfort to the patient and help him achieve a comfortable end to life. Given that everyone would want to avoid a painful death, pain relief is perhaps most important in these cases where the patient is terminally ill. Realizing that they will all one day approach death, which may be painful if palliation is not available, reflective citizens would probably agree that services that are necessary to help ease the pain of those who are dying, such as palliative care, should be funded.

Emphasizing the importance of pain relief can help us acknowledge and accept the reality that health care cannot extend life indefinitely. In cases where patients are terminally ill, an emphasis on health care as an important pain-control measure allows us to think of pain-relief as a legitimate and important way of caring for patients rather than as unfortunate failure of medicine. It also allows us to rethink the contemporary tendency to push the meaning of premature death. As I mentioned in an earlier section, medical advances no doubt have saved many patients who would otherwise have died of various diseases and injuries. Such "miracles" have invited the thought that almost any death caused by diseases and injuries can be considered premature, since we seem to be expanding the "natural life span" everyday with such technologies. However, we should not think that all deaths are premature and unacceptable. Given that we are mortal beings, we will all approach death at some point. Redirecting the focus on relieving pain in cases where the patients' conditions cannot be restored can help the patients achieve a comfortable and peaceful death. Such a focus can help us face the possibility that further intervention in some cases may subject the patient to additional pain and suffering without improving the underlying condition or ultimate outcome. By balancing the goals of restoring conditions and providing care for the suffering, we can also avoid the problem of ignoring the final and possibly the most important needs of terminally-ill patients.

What Services Should a Deliberative Democratic State Fund?

So far I have argued that deliberative parties would probably want to establish universal health care so as to prevent premature death, restore normal functioning that affect opportunity range, prevent various maladies and injuries, and ameliorate pain and suffering. However, given that resources are scarce, these parties would realize that not all services that may somehow contribute to these goals can be funded. They would therefore still need other criteria in deciding which services should be included in the tax-funded scheme. In the remaining sections of this chapter, I shall discuss what kinds of principles would likely be accepted by the deliberative parties when deciding what kinds of services should be funded and who should receive such services.

Certainly, through discussions on what kinds of health-care services should be funded under the tax-funded scheme, reflective citizens will realize that they cannot provide all or even most beneficial services without sacrificing some other goods or charging additional taxes. Given that part of the purpose of having public deliberation is to promote people's autonomy by giving them a chance to influence the political decisions that may affect them, it is likely that the deliberative parties will want to limit the amount of taxes that the government can charge. They will therefore have to decide together the relative importance of various health-care services compared to each other and to other social goods, such as education and housing. Discussions of how the parties may deliberate on such issues is beyond the scope of this chapter. Here I shall only focus on how the parties may decide on which of the beneficial services should be funded once they have determined the budget for the health-care system.[161]

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[161] However, the budget of the system can be subject to change. If the deliberative

The Criterion of Efficacy

In deliberating on what kinds of services can achieve the aforementioned goals of establishing a tax-funded system, I argue that the deliberative parties would likely consider whether various treatment options are indeed proven to be effective in achieving such goals. After all, it seems unreasonable to spend scarce resources in areas where the success rates are low, especially when the intervention methods are expensive.[162]

An example can help illustrate my point. In deciding whether a new therapy for advanced-stage breast cancer should be funded, people who deliberate to make allocation decisions need to determine whether such therapy can improve the outcome for patients with the ailment. After setting out this criterion of efficacy, the deliberative parties may consult experts and see if the new therapy meets such a criterion.[163] For example, did a significant portion of patients engaged in various well-designed randomized clinical trials go into remission after receiving such intervention? Is there a consensus among the experts that such intervention can actually ameliorate these patients' pain and suffering, restore their functioning and opportunity range, and prevent them from dying prematurely? What is the length of survival and quality of life during survival after such intervention for representative patients? What is the chance of recurrence? If it turns out that the results of such clinical trials are promising for patients with advanced-stage breast cancer, then deliberative parties may consider funding such intervention. However, if the intervention method has not been proven by the medical community to be effective, the deliberative parties probably will not

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parties realize that they may have to forgo some of the very important health-care services, they may adjust the budget or funding for other social programs.

[162] This is one of the reasons why funding IVF for women who are infertile is so controversial. The success rate for such expensive procedure is low (e.g., 8% in Canada). Women who use such method may have to receive multiple treatments before getting pregnant.

[163] Medical experts may in fact be part of the inclusive deliberative parties in the sense that they are the information providers in the deliberative process.

want to fund such intervention.[164] After all, if the expensive procedures may not even achieve various goals of establishing universal health care, spending lots of money on such procedures seems to be a mere waste of resources that are already limited.

Comparative Cost-Efficiency and Prioritization

What is worth noting is that being effective is not a sufficient criterion of warranting funding for certain treatment. There may be a time when different intervention methods are all proven to be effective in treating certain ailments and thus beneficial for the patients. However, that does not imply that the deliberative parties would propose to fund all effective services. Nor does it demand that we have to fund the best possible treatment. As Veatch (1992) points out, many intervention methods are effective, and funding all of them may consume the entire gross national product. He argues that sometimes additional resources may not provide a significant increment of benefit, and it is therefore reasonable for any insurance plan that has coverage limits to refuse funding such services.

Two conclusions may be reached by Veatch's argument. First, his line of reasoning implies that certain beneficial procedures should not be funded if the expected benefit is not significant enough to justify the costs. For example, there may be situations where extremely expensive treatments can provide the patients minimal benefits for a relatively short duration. Given that every insurance policy has coverage constraints, it is unreasonable for the scheme to fund such services, since the resources can be used in ways that are much more efficient and equitable (Veatch, 1992).[165] Second, Veatch's argument implies that we should use a comparative cost-efficiency approach in deciding which of the numerous beneficial interventions for a particular ailment should be tax-funded. To ensure that the allocation policies can achieve the goals of establishing universal health care effectively and efficiently, when we are dealing with two or more treatment options that are all beneficial to patients, we need to compare their relative cost-efficiency. Certainly, there are *prima facie* reasons why deliberative parties may want the tax-funded scheme to fund the services that are most effective, since they offer the best chance for the patients to minimize their pain and suffering, restore their functioning, and prevent premature deaths. However, the fact that resources are limited may demand that they have to see if the comparative advantage the most superior treatment offers is worth the additional costs.

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[164] This line of reasoning seems to be adopted by various provincial insurance policies in Canada. For example, the Alberta Health Care Insurance Act states that "services that the Minister, on review of the evidence, determines not to be health services because the services ... are experimental or applied research," should not be covered by the provincial insurance plan (Alberta Health Care Insurance, 20(h)).

[165] An example may illustrate Veatch's point here. Suppose a patient suffers from multiple-organ failure and will likely die within two months if he does not receive multiple transplants. Let us also assume that a donor heart becomes available, but not other organs that are also necessary to save the patient's life. While giving this patient a heart transplant

I acknowledge that the employment of such an allocation criterion implies that the patients may not receive what is literally medically best. However, as Veatch (1992) points out, in a world of finite resources, it is simply "irrational for a society to support a health plan that would do what is literally medically best for patients, when cutting slightly below that point would release resources to be used in ways that were much more efficient or equitable" (p. 79).[166] Spending an enormous amount on procedures that do not offer a reasonable amount or chance of additional benefit does not seem to make economic or social sense. It bears a high opportunity cost, since we probably have to give up other more important services, or charge an unreasonably high amount of tax dollars to cover all the services.

A second look at our previous example can illustrate my point. Suppose in the future researchers find that both standard therapy and the new intervention for advanced stage

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may provide him slight benefit, without receiving other new organs he will still die shortly. Veatch will probably say that, given that the heart transplant at this point will not provide significant relief for the patient for an extended period of time, such a patient should not receive funded heart transplant, if he should receive the transplant at all.

[166] Daniels (1991) echoes this point. Although he believes that a society should try to provide services that are essential to restore functioning, he argues that this "does not imply that any technology which might be a positive impact on normal functioning for some individuals should be introduced" (p. 205). We must try to provide just health care "within the conditions of moderate scarcity that we face" (p. 205).

breast cancer are effective in treating such patients. In addition, let us assume that the latter intervention is slightly better (e.g., it extends life for a couple more months) than the standard therapy but is extremely expensive compared to the former intervention. In other words, using the new intervention method instead of standard treatment will produce declining marginal utility. Given this information, the comparative approach demands that, although both of these treatment options are effective, the tax-funded scheme should only cover the standard and not the new therapy.

However, the situation may be trickier if the additional costs for the better treatment is moderate and that the benefit may be more than minimal. One example of such cases is cataract surgery. One of the latest and marginally more expensive techniques, which uses a foldable lens, allows the surgeon to make a smaller incision than the current standard procedure. After the old clouded lens is broken up with an ultrasound device and suctioned out through the small opening, a new foldable lens can be slipped into place (O'Day, 2000). The smaller incision makes the wound smaller and it heals with less disturbance of the eye. It also lowers the risk of traumatic rupture, and patients can go back to their normal activities sooner than with the older technique. However, the final result with either of these methods is the same in the long run. O'Day (2000) reports that a couple months after the surgery, there is no detectable difference between eyes operated on by one method or the other. In other words, the new method provides more benefits in the short run but not in the long run.

The question is, would the deliberative parties want to fund the newest technique? There are a few issues that the reflective citizens will have to consider. First, when these citizens review the information on cataract surgery, they will realize that about half of the population between the ages of 65 and 74 have cataract. This number increases to about 70% of the population over 75. Given that people's life expectancy is increasing, the deliberative parties will realize that such a condition will eventually affect many of them. Knowing how many people may be affected by the possible funding of the new treatments has two implications. When more people's conditions can be improved by the new treatment, it is reasonable to assume that more people will support funding this newest treatment. However, at the same time more people being affected implies a substantial total cost increase if we fund the new treatments. So the deliberative parties will have to see how they can balance these issues.

In determining whether the government should fund the new procedure, the reflective citizens will also have to decide whether the short-term benefit is substantial enough to be worth the additional costs. For example, they will have to consider whether the current treatment is "good enough," that is, it can restore their functioning and opportunity range in a relatively short period of time. They will have to see .if the discomfort that patients experience after their surgeries is minimal or substantial. If patients do experience substantial pain, the reflective citizens will also have to find out whether patients will have to endure such pain for an extensive period of time, and whether there are safe and yet cheaper ways to reduce such pain (e.g., whether prescribing painkillers may suffice). I think the deliberative citizens will probably decide on this matter based on clinical findings. If the evidence shows that patients who undergo the standard surgeries may have to endure severe or prolonged pain and that the new technique only causes minimal discomfort, the deliberative parties will likely decide to fund the new technique. After all, one of the goals of establishing universal health care is to ameliorate severe and prolonged pain, so the deliberative parties will probably prefer a procedure that can better achieve such goal, even if that may cost more.[167]

Expensive but Beneficial Interventions

One of the questions that may arise in the debates on cost-efficiency analysis is how the deliberative parties may deal with cases where certain health-care services are extremely expensive but can offer *substantial* benefits to patients. Certainly, if the benefits are minimal, there are good reasons for the parties to reject coverage for those interventions, since such interventions may not significantly help to achieve various goals of establishing universal health care. However, the issue is trickier if the intervention is believed to be highly beneficial and is the only effective intervention for certain patients.

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[167] However, if it turns out that the pain that patients experience after receiving the standard surgery is minimal or temporary, the deliberative parties may decide to not fund the new treatment. After all, given that many people are affected by cataract, the total costs of funding the new treatment will be relatively high, and the citizens may prefer to spend that money on other procedures.

One of such examples is liver transplants. For those who suffer from end-stage liver disease, the only chance for them to restore functioning and prevent premature death is by receiving a liver transplant. However, the problem is that such intervention method is extremely costly. Not only are the procedures and the medicine extremely expensive, there is also an absolute shortage of transplantable organs, which are nonrenewable resources (Moss and Siegler, 1991). Given our previous analysis of relative importance of rescue versus preventive medicine in the long run, would the people in the deliberative democratic state agree to fund such high-technology procedures that are extremely expensive and can perhaps only benefit few patients?[168]

I argue that the deliberative participants have good *prima facie* reasons to include procedures that are expensive but highly beneficial under the government scheme. After all, one of the reasons why establishment of publicly-funded health care is essential is that some people may need urgent medical help that can prevent premature deaths or restore functioning but cannot afford it. Most people can perhaps afford cheaper services or buy insurance coverage for such services. However, problems arise when the patient suffers from catastrophic illnesses or injuries that may only be corrected by expensive treatments. If the government scheme consistently rejects coverage for expensive but beneficial treatments, then it seems that the system defeats its purpose.

Moreover, as I have mentioned, health-care allocation decisions often have more impact on the poor than the rich. If the government does not fund various expensive but beneficial treatments, we can imagine that those who are economically disadvantaged or even in middle class probably will not have the resources to purchase such procedures that are essential to restore their equality of opportunity, while the rich may be able to purchase them.[169] It is unclear that denying coverage for such beneficial procedures, which can ameliorate patients' pain and suffering, restore their fair chance of leading an autonomous life, and prevent them from dying prematurely, will be or even should be agreed upon by all parties. After all, as I mentioned, denying coverage may defeat the original purpose of establishing tax-funded health care in the first place, and so it is unlikely that the deliberative parties will mutually agree to exclude such beneficial procedures from coverage.

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[168] Part of the reason why relatively few people can benefit from such procedure is that transplantable livers are extremely scarce. Unless the organ-donation rate increases drastically, even if the procedures are being tax-funded, most people who need a liver transplant to survive still cannot benefit from such intervention method.

However, my argument does not imply that the deliberative parties would want the government to pay for all expensive but highly beneficial services. Given the high costs of such procedures and the fact that resources are scarce, the deliberative parties would probably realize that it is simply impossible to provide all such services to everyone who needs them (e.g., there may simply not be enough livers to go around). They would also realize that trying to pay for all expensive procedures may result in the possibility that many other equally beneficial services will be sacrificed. These other services may benefit more people in the long run, and so people in the democratic state may not want to give up such services. In this way, to ensure that the allocation policy may not sacrifice other important services, people in the democratic state may not want the government to fund *all* expensive services.

So the question is, how may people decide which of the expensive but highly beneficial procedures should or should not be funded? If we cannot fund or provide every expensive but beneficial service, people in the deliberative process still need other criteria to decide which patients should receive priority. We shall now turn to the question of criteria the deliberative parties may use in making such decisions.

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[169] This, of course, assumes that the deliberative parties allow a multi-tiered system that permits people to purchase services that are not covered by the tax-funded scheme. I shall discuss the moral implications of such a system in the next chapter.

Problem of Responsibility

One of the criteria that is sometimes recommended for determining whether expensive treatments should be funded is that of causal responsibility. In recent decades, scientists have found or are getting closer to finding out the causes of various diseases and illnesses. The discovery that health status is often affected by personal lifestyles or actions has prompted many to argue that it is legitimate for the government to deny coverage for expensive services when the injuries and illnesses are "self-inflicted" (Glannon, 1998; Moss and Siegler, 1991).

In determining whether the deliberative parties all have good reasons to accept responsibility as an allocation criterion in expensive cases, we need to first clarify what it means to say that someone is responsible for her condition. Glannon (1998) argues that, if "a person has causal control over the events that determine his healthy or diseased condition, he is causally responsible for these events as well as for this condition" (p. 33). If the person "is able but fails to exercise the control he has in accord with how he reasonably can be expected to behave," he is also *morally* responsible for his condition (p. 33). In explaining his argument, Glannon (1998) suggests four criteria in determining that someone has causal control over his or her condition. First, the person's choices and actions must not be coerced by external factors or compelled by internal factors that may rule out any genuine alternative possibilities of choice. Second, the person has to be autonomous, i.e., capable of reflecting self-control regarding the desires, beliefs, and intentions that issue in choices and actions. Third, the person has to be able to foresee that his actions are likely to lead to his diseased condition in the future.[170] Fourth, there has to be a "causal sensitivity" between the choices and actions that a person makes over time and the diseased condition. What this means is that, holding fixed all other external elements, if the patient had made different choices and performed different actions, he would not have obtained his diseased condition. Notice that this causal sensitivity requirement, which is formulated in counterfactual terms, allows the possibility of multiple causes and still hold the patient responsible for causing his ailment.

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[170] Earlier in this chapter, I argued that reflective citizens would likely agree that various important preventive measures, such as immunization and educational programs, should be covered by the government scheme. If such measures are in place and information regarding various diseases and injuries are publicly accessible, then according to Glannon people should be able to foresee the connection between their actions and their diseased conditions.

Given that most people are capable of knowing that health-care resources are scarce, Glannon (1998) argues that people should also be capable to infer that such scarcity might require some kind of prioritization based on control and responsibility. When educational programs are in place such that information regarding various diseases and injuries are widely available, one may argue that a person can be expected to follow such advice and take various precautions. For example, public announcements and other educational programs in the last few decades have warned people the danger of long-term smoking. There are now even explicit signs on cigarette boxes to inform smokers that smoking can cause cancer and other fatal diseases. In other words, such warnings are readily available to everyone who smokes. If it turns out that one is aware of these warnings and is capable but fails to exercise causal control, according to Glannon's arguments it is legitimate to give the patient lower priority in receiving scarce medical resources.

Glannon (1998) reminds us that these criteria do not address the issues of virtue and vice. Giving smokers lower priority to lung transplants, for example, is not because smokers are morally bad. Rather, the reason is simply that these people had control over their behaviours and thus their conditions but that they did not exercise such control. Reframing the question of priority in terms of control and responsibility, we can imagine that these criteria apply to all sorts of cases regardless of the moral judgement of these respective cases. They do not try to single out certain socially unacceptable or morally suspect behaviours. For example, they apply to cases where the actions involved may be judged immoral, such as HIV infection caused by intravenous drug use or promiscuity, and also others where the actions may be morally neutral, such as skiing accidents caused by inadequate safety precaution. By staying away from the issues of virtue and vice, Glannon's account is attractive because it avoids the problems of possible discrimination against certain lifestyles or population groups.

Nonetheless, it is unclear that people in the deliberative democratic state would accept Glannon's way of using responsibility as a criterion in making allocation decisions on a micro level in most cases. As I have mentioned earlier, Glannon's argument seems to allow holding someone morally responsible for causing his condition even if there are multiple factors that may all have contributed to the person's diseased condition. One of his criteria of causal control and responsibility, i.e., the criterion of causal sensitivity, is formulated in counterfactual terms. If we think about end-stage liver diseases, to satisfy Glannon's criterion of causal sensitivity, it does not require that all or only alcoholics develop end-stage liver disease. Rather, it asks whether the patient would have had such disease if he did not drink. If the answer is no, then the patient can be considered causally responsible for his ailment. This criterion allows other factors co-contributing to the patient's disease, such as genetic factors.

However, deliberative parties may not find such a counterfactual criterion helpful. Recall that part of the reason why we need a combination of preventive and curative medicine is that we are ignorant of many causal links between lifestyles and diseases or injuries. In many instances, there are multiple factors that all *possibly* contribute to one having a certain disease or being injured. For example, it seems that end-stage liver diseases are not the result of a single factor. While heavy drinking *can* accelerate and worsen the problem, other factors may also affect one's chances of developing liver disease. The fact that those who do not drink and have taken every precaution may still in the end develop such a disease shows that there are other contributing factors that are beyond one's control. In other words, even if we apply the counterfactual criterion of causal sensitivity, it seems that we may still say that drinking is not causally sensitive to alcoholism. After all, even if the patient had made different choices and performed different action, i.e., did not drink, he could still have developed end-stage liver disease. In this way, it may be problematic to restrict certain patients access to expensive treatment on the ground that they have causal control over their condition. After all, it seems that we simply do not have a complete understanding of the causal factors that may lead to a patient's having a disease, such as which of the factors may have triggered the disease. In other words, there are epistemic restriction on how useful Glannon's counterfactual criterion may be. When a disease is possibly caused by a combination of various factors, some of which are unknown and may not be under the patient's control, we may be punishing these patients based on morally arbitrary factors.

Perhaps the deliberative parties can restrict Glannon's responsibility criterion of causal sensitivity to single-cause conditions and conditions that have clearly-identified causal factors and sequences. If we can clearly establish causal effect between one's action or behaviour and the resulting condition, the deliberative parties may then take the issue of responsibility seriously in making allocation policies for expensive treatments.

There are three possible reasons why the reflective citizens may agree to a government scheme that does not cover expensive procedures that treat the aforementioned single-cause conditions and those that have clearly-identified causes. First, resources are scarce. Part of the reason why we need to have a deliberative process to resolve various allocation dilemmas and prioritize various health-care services is that we may not have enough resources to provide all services that are needed to relieve people's pain and suffering, prevent maladies, restore functioning and opportunity, and prevent premature deaths. Facing allocation dilemmas, these goals may still be too broad to provide guidance in resolving such dilemmas. Responsibility allows the reflective citizens an additional criterion to resolve these dilemmas by distinguishing various conditions and see which of them should be prioritized. In resolving allocation disputes on the micro level, it also helps the deliberative parties to distinguish different patients and decide who should have higher or lower priority in receiving scarce resources.

Second, democratic societies that care about autonomy focus on minimizing *undeserved, uncontrollable, or morally arbitrary* disadvantages.[171] In other words, the deliberative parties are likely to be sensitive to *how* one may end up in one position or another. They may want to have some ways of explaining economic and social pluralism. For example, the deliberative citizens need to be aware of how various social and historical factors may have contributed to such inequalities. As we have seen in chapter two, social structure and history may have been responsible for various individuals being in certain disadvantaged conditions. If it turns out that one's disadvantaged position is the result of such social circumstances that are beyond one's control and are thus morally arbitrary, there are good reasons to correct such unfair result. However, if such social conditions are not the cause of one's condition but that an autonomous individual is causally and morally responsible for his own condition, then it seems that the resulting disadvantages are not uncontrollable or morally arbitrary. In other words, the correction of such disadvantages will probably not be the main concern of a democratic society.[172]

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[171] As I mentioned in chapter two, even the UN declaration seems to agree that only those who are in dire condition because of factors beyond their control have a "right" to be helped.

Third, people in the democratic state may not want to pay for others' "mistakes." If the patients are also autonomous beings and could have taken precaution to avoid contracting a certain disease or getting injured but have failed to do so, it is unclear why others have to pay for the results of such negligence.[173] As Glannon (1998) argues, when people have the capacity to control certain events but fail to exercise such control within reasonable expectations, they may be considered morally responsible for their own conditions and thereby weaken their claim to scarce resources.

These responses have some intuitive appeal. First, as autonomous beings, we have the ability to control our behaviours. As we have seen in chapter two, part of the reason why the individualist approach of rights is somewhat attractive is that it gives autonomous individuals ultimate authority over themselves. It assumes that individuals have the capacity to determine what they do and do not want to do and thus have the right to make such decisions on their own. In fact, one of the reasons why some believe that human beings may have higher cognitive or even moral values than other beings is that human beings have such ability to make decisions for themselves. It also seems that we have to assume that people are capable of controlling themselves at least to some extent. Without going into details, I contend that any society has to assume that people have some free will in the sense that people are capable of making decisions on their own and can act accordingly. Otherwise we need to abolish punishment and can never hold people accountable for their actions.

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[172] Certainly, this is highly controversial, partly due to the difficulty of identifying various causes and thus the danger of blaming on possibly innocent victims. However, as we shall see shortly, one may argue that *at least in clear-cut cases* one can legitimately employ the responsibility model in resolving allocation disputes.

[173] Recall that libertarians argue that others should have to pay for one's health care only if *others* have caused one's conditions. So if one has caused one's own condition, then libertarians will certainly say that one should have to bear the costs for treating such condition.

Second, as social beings, it seems that we should seriously consider how our actions may become a burden on others. In fact, part of the reason why an inclusive deliberative approach is attractive in making allocation decisions is that people cannot simply make self-serving decisions. They are accountable to each other when their decisions and actions may affect others. They have to justify to each other why they will continue to act in certain ways when their actions are known to have negative impact on others. In deciding whether responsibility should be a factor in making allocation decisions, people who are aware of the expenses of treating various conditions that are avoidable have to publicly justify why they should not have to exercise such control and at the same time be paid for the costs of their actions. This discussion and public justification are especially important when the resources that are needed to treat some of these self-inflicted conditions (e.g., AIDS caused by intravenous drug use) are disproportionately high. I argue that when the deliberative parties reflect on the costs of various treatments and the possibility of preventing the need for such treatments, they are likely to mutually agree to use causal responsibility as an allocation factor. When autonomous individuals have the right and capacity to exercise their liberty in pursuing their life goals, it is unlikely that they can convince other taxpayers that they themselves should not be accountable for their actions and the consequences of such actions, but that others should bear the costs for their actions.

However, deliberative citizens may still be reluctant to use causal control as a criterion for allocating scarce health-care resources among patients because it may conflict with one or more of the goals of establishing universal health care. First, as I mentioned before, one of the goals of establishing universal health care is to relieve patients' pain and suffering. This goal has a humanitarian focus that does not seem to rely on the issues of autonomy or functioning. It simply relies on the common intuition that everyone wants to avoid excessive pain and suffering. It is therefore unclear that people will mutually agree to ignore the needs of those who have caused their conditions when such conditions may be severely harmful.[174]

Second, we may only be able to find out various causal factors by intrusive measures that will violate confidentiality and privacy. For example, in order to find out how a patient is infected with the AIDS virus, we need to look at the patient's previous medical record to see if he has received blood transfusion. We also need to find out whether the patient had unprotected sex, intravenous drug use, whether his partners are also infected with the virus, and so on. Assuming that the deliberative citizens value their privacy, it is unclear that they would use responsibility as an allocation criterion when determining responsibility may require violation of people's privacy.

Perhaps causal responsibility would only be accepted by the deliberative parties as an allocation criterion in some rare cases. For example, when the resources are *extremely* scarce, and that there is clear-cut evidence to show that the patient had causal control over her condition, people may agree to hold the patient morally responsible for her condition and give her lower priority in receiving the scarce resources, such as organ transplants and other extremely expensive treatments. When we simply do not have enough resources to save everyone in need or to protect them from pain and suffering, causal responsibility may be a relevant factor in deciding who should receive priority in getting such resources.

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[174] Perhaps the deliberative parties will decide to pay for pain-relief services but not the expensive treatment. So in the case of someone who contracted the AIDS virus through intravenous drug use, the party may not pay for the expensive cocktail therapy but for pain management and hospice care.

What Else Can We Do?

In this chapter, I have argued that people in the democratic state who deliberate with each other in forming allocation policies will mutually agree to a decent level of health care to ensure that people do not suffer from excessive pain, restriction of opportunity range, or die prematurely. Given that resources are scarce and that the public sector can only fund a portion of services that may help achieve such goals, the question now is whether these deliberative parties may mutually agree to allow their fellow citizens to purchase some of these insured and uninsured services in the private sector. So far our discussion has only dealt with what the public sector has to provide. It has been silent on the issue of whether the private sector can or should be allowed to share the burden of providing people access to various medical services. It is to this issue I shall turn in the next chapter.

CHAPTER SIX

THE MORALITY OF MULTI-TIERED SYSTEMS

In the last chapter, I argued that it is a legitimate and also an essential role for the government to provide a decent level of tax-funded universal health care that is decided by an inclusive deliberative process. However, this is not the end of the issue. We still need to examine what this role entails and prohibits. For example, does establishing tax-funded universal health care imply that tax-payers should not be allowed to purchase various health-care services in the private market after they have contributed to the public sector? Will the deliberative parties agree that the government has to guarantee not only access but access on equal terms and conditions? In other words, do the deliberative parties believe that their commitment to provide a decent level of health care to all prohibits multi-tiered systems? Can universal health care and private market coexist legitimately in a democratic state?

Some argue that multi-tiered systems, which allow the rich to have access to more and possibly better care, are inherently problematic. Many of their arguments concentrate on attacking the unequal access in the privately-funded tier, which allows the rich to purchase better or additional services. In this chapter, I shall argue that this focus is misguided, and that we should concentrate on the publicly-funded tier. I shall argue that whether a multi-tiered system is defensible depends largely on the strength of the public tier. If various mechanisms are in place to ensure a strong public tier that can protect and promote the interests of the least advantaged, multi-tiered systems can be justified despite unequal access in the private tier.

As we have seen in the last two chapters, it is legitimate for the democratic state to redistribute resources to establish universal health care. Such provision is important in helping to ensure that undeserved illnesses or injuries would not lead to excessive pain and suffering or premature deaths. It is also important in permitting people to have a fair chance to lead an autonomous life. However, as we have seen in the last chapter, given that resources are scarce, there will always be health-care services that are beneficial but cannot be covered by the publicly-funded scheme. The question is, once the tax-payers have fulfilled their obligation to redistribute some of their resources to provide a decent minimum level of basic health care to all, can they legitimately prohibit certain population groups (e.g., the rich) from purchasing better or additional services in the private market? At the same time, can they legitimately forbid practitioners from setting up their own private practices to provide various services?

Multi-Tiered Systems and Unequal Access

There is a lack of philosophical evaluation or analytic discussion of the morality of multi-tiered systems, although many Canadian economists and political scientists have discussed some general concerns about such systems. Those who explore the issue of justifiability of multi-tiered systems often employ the arguments of equality and fairness in evaluating the relative justifiabilities of single-tiered and multi-tiered systems. Those who criticize multi-tiered systems argue that people should be considered as equals, and therefore everyone should have equal access to various health-care services regardless of his or her economic situations. According to these opponents of multi-tiered systems, economic positions are morally arbitrary and should not affect one's access to services as important as health care. For example, some believe that Canadians support their health-care system mainly because it is fair and ensures a uniform, high-quality standard of care for all citizens (Pollock, 1993). Under the Canadian system, people's access to various medically-necessary services is not affected by their social or economic status.[175] The rich and the poor use the same facilities, and they have same access to the same services. Some argue that the alternative, i.e., multi-tiered systems, will necessarily affect the quality of care in the public tier in a negative way, so that the poor will be using services of lower qualities compared to the rich. Opponents of multi-tiered systems argue that such systems, which allow unequal access in the sense that people who have more economic resources can purchase more or better care, are inherently inegalitarian or unfair. They argue that multi-tiered systems are unjust because individuals should not be allowed to purchase a quantity or quality of health care that is greater than or superior to the health care available to everyone else because of some morally arbitrary factors, such as their ability to pay.

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[175] However, some believe that there is still unequal access within the public system in Canada. Educated and wealthy people visit specialists more often. This may be because those who are educated tend to do more research on the services available and request for these services more often.

While I agree that equality is an important concern in evaluating a health-care system in a democratic state, this does not imply that multi-tiered systems are necessarily illegitimate in such a state. It also does not imply that any system that allows disparity is inegalitarian or unfair. As Rawls (1971) says, egalitarianism admits of degrees. Some conceptions of justice are recognizably egalitarian, although certain significant disparities are permitted (p. 538). In this chapter, I shall argue that we need to examine inequality within the democratic framework in evaluating the legitimacy of unequal access in such a state. I shall argue that disparity that is to the advantage of the worst off, or at least does not further disadvantage them, can be justified. I shall argue that the parties will probably agree with me that the inter-related arguments of respect for autonomy, basic equality, consistency, and difference principle can all support certain types of multi-tiered systems in a democratic state.

Fairness and Equality: Do They Require Uniform Access?

The question that we need to deal with is whether the democratic commitment to a fair and equal health-care system implies that we have to prohibit all forms of unequal access in such a system. In order to answer this question, let us first remind ourselves some of the reasons why equality plays such an important role in discussions of allocation of health-care resources.

As we have seen in previous chapters, health care is often considered special by liberal philosophers because it is essential to ensure that people can achieve one of the fundamental liberal values, i.e., equality of opportunity (Daniels, 1985). Illnesses and injuries can hit anyone, and very often such conditions may inflict undeserved suffering or take away people's chances to carry out their life plans. In order to ensure that people do not have to suffer from undeserved disadvantages caused by illnesses and injuries, some argue that health-care resources should not be distributed arbitrarily, but should be allocated in such a way that it would effectively and efficiently promote or restore equal opportunity range.

I agree that a health-care system in the democratic state should consider promoting equality of opportunity as one of the most important factors. As I have argued in the last chapter, one of the factors that the deliberative parties consider in deciding what services should be covered is how various illnesses and injuries may affect people's functioning and opportunity range. The deliberative parties who care about equality will try to arrive at a mutually acceptable level of tax-funded health care to ensure that people do not have to endure excessive pain and suffering, lose fair equality of opportunity range, or die prematurely because of various health conditions and poor economic status.

The question is how much or what kind of equality is necessary. As I mentioned, there are many forms of equality, and an egalitarian scheme may still allow some forms of disparity. When various parties come together in making allocation policies, how much or what kind of equality should be acceptable to all parties involved? I have already argued in the last chapter that the deliberative parties would realize that there are budget constraints such that the tax-funded scheme would not be able to pay for all beneficial services. Acknowledging that the government cannot provide all services but should ensure equal access to all tax-funded services in the public sector, we need to examine whether that implies that various population groups would agree to disallow people from purchasing non-insured or even some insured services in the private market.

For the purpose of this chapter, I shall only discuss two distinct types of multi-tiered systems and examine whether they are in accord with the goals of a democratic society.[176]

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[176] There may be other kinds of multi-tiered systems. For example, one can imagine a system in which the government only provides limited coverage for some but not all citizens. In this system, those who are not covered have to purchase their own coverage in the private market, pay for various services out of pocket, or rely on charity hospitals to provide them access to various essential services. This resembles the situation in the United States. However, since I have already argued that the government ought to provide *universal*

First, we may have a multi-tiered system in which the government is the single payer that provides universal basic health-care services while the privately-funded non-basic or "luxury" tier provides services that are beyond such level. Second, we may have a system in which people are allowed to purchase various insured health-care services in the private market.

Private Market for Uninsured Services

The legitimacy of the first type of multi-tiered system that allows people to purchase uninsured health-care services is based on two premises. The basic and publicly-funded tier fulfils the government's obligation to meet its citizens' basic health-care needs and thus helps promote equal basic condition for all. Second, the privately-funded tier recognizes the limits of communal authority over what one may do with one's private resources and energies (Engelhardt, 1992). In other words, it respects the right of individuals to deploy their private disposable resources to purchase non-basic services if they so wish.

Regarding the first premise, i.e., the public tier ensures that people can enjoy equal basic condition regardless of their wealth and social status, I have already argued in the last two chapters that it is legitimate for the government to enforce redistribution to finance (only) basic health care for all. I shall not repeat the arguments here. What I am more interested in here is whether the second premise, i.e., a multi-tiered system recognizes the limits of communal authority and thus the right of individuals to deploy their disposable income, is valid. I want to examine whether it provides a good justification for allowing people to purchase uninsured and non-basic services in the private system regardless of the fact that not everyone may be able to afford such services.

Basic Equality

In the last chapter, I argued that people in the deliberative process should agree that the government ought to provide a decent minimal range of basic health care. Given budget

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coverage, I will not spend time on this type of multi-tiered system.

constraints, not all services will be covered by the government insurance scheme. There will still be various beneficial procedures that may not be urgent or necessary to ameliorate excessive pain and suffering, restore people's functioning, or prevent premature death. For example, they may help speed up one's recovery or further expand one's activity range. We can imagine that a patient with lower-back injury may recover faster if she receives not only physiotherapy but also daily massage. However, given that resources are scarce, it is impractical and unreasonable to fund all beneficial services under the public scheme. Given budgetary constraints, the deliberative parties may decide to pay for the physiotherapy but not daily massage. When certain beneficial services are not covered under the public scheme, the question is whether the deliberative parties will mutually agree that well-off patients should be allowed to purchase such uninsured services, when the poor will not be able to afford the same kind or level of care. For example, should the aforementioned patient be allowed to pay for and receive daily massage?

As I mentioned, many who argue against multi-tiered systems believe that a commitment to equality prohibits a system that allows some people to purchase better or more care than others. This implies that the patient discussed above may not legitimately purchase daily massage if others cannot afford the same luxury. However, this argument fails to consider the fact that people in a democratic state care about not only equality but other values as well, such as autonomy. Certainly, the deliberative parties will want to make sure that everyone's health-care needs are protected. They will try to protect the well being of the poor and make sure that the disparity in access is not unacceptable. In designing a health-care system, they will try to ensure that the condition of the indigent and the sick may not fall below a threshold level while others in privileged positions are enjoying various kinds of luxury. This is why the deliberative parties will be committed to improving the condition of the impoverished and strive for equality of *basic condition*, so that everyone has a fair chance to live an autonomous life. Given this commitment, they need to ensure that the tax-funded scheme provides everyone equal access to a decent range of basic health care.

However, the goals to achieve basic equality and to improve the condition of the impoverished do not imply that the deliberative parties will try to prohibit any inequality above the basic level. It also does not imply that they ought to employ a radical or strict egalitarian position to guarantee an equal distribution of services such that the state either funds all beneficial health services or ensures that no one can purchase such services in the private market. In fact, our discussion in the last chapter showed that the deliberative parties' goal is to try to *provide* and *not restrict* access to health care. When the parties are being constrained by budgetary limits and cannot provide all beneficial services, it seems unreasonable for them to prohibit people from getting such services on their own. It is unclear how the opponents of multi-tiered system of this sort can publicly justify to others their judgement that no one should be allowed to provide or purchase uninsured services in the private market. This problem arises partly because another goal of a democratic state is to promote and protect people's autonomy. Given that people have to respect each other's choices when such decisions do not harm others, there are good reasons why the deliberative parties will not want to forbid each other from using their disposable income to purchase uninsured services.

Protection of Autonomy and Unequal Access

The last point brings me to another important justification for a multi-tiered system that allows people to purchase uninsured and possibly luxury services in the private market. Recall that one of the reasons why liberals advocate for tax-funded health care is partly because having a decent minimum level of *health* is essential to pursue one's self-chosen life plans and live as fully functioning citizens. When people do not have access to various essential preventive and curative treatments because of their economic conditions, they are at an unfair disadvantage, since their chances of remaining healthy or recovering from illnesses and injuries are low. This in turn implies that their chances of leading autonomous lives can be or are severely reduced. As Daniels (1985) argues, health care is important because it is closely linked to one's ability to achieve fair equality of opportunity. Given that people in a democratic state worry about *autonomy*, which provides a justification for tax-funded health care, people in the deliberative process will probably try to ensure that the resulting system does not overly restrict taxpayers' liberty to use their disposable resources the way they see fit. They will probably also refrain from forbidding people to enter into various agreements that do not harm others. For example, the deliberative parties are unlikely to disallow people from purchasing uninsured services, or prohibit health-care providers from entering into agreements with people to supply various health-care services.

Engelhardt (1992), for example, argues that the most fundamental justification for allowing private health care is that no one has the secular moral authority to forbid it. Certainly, as I have argued in chapters two and three, there are lots of problems with the extreme libertarian view, which does not even allow a tax-funded public tier to help those in the most desperate conditions. However, granting that the multi-tiered system at stake *does* have a publicly-funded tier that provides a decent minimal level of basic health care to ensure that no one's condition falls below a threshold level, it seems that there are good reasons to say that various deliberative parties cannot legitimately forbid each other from buying or selling uninsured health care in the private market. In a democratic society, which adopts a thin theory of the good, individuals are in general allowed to find employment of their choice and use their *disposable* resources to pursue their own concepts of a good life.[177] In other words, individuals may freely engage in various activities or enter various types of contracts that may fit their rational life plans or enhance their well-being. Once the citizens have discharged their civic duty to contribute to the universal health-care system, they should be allowed to purchase uninsured and possibly "luxury" services that suit their concepts of a good life, as long as they do not harm others by doing so.

Consistency Argument

What is interesting about this autonomy argument is that liberal states do respect people's autonomy regarding what they can do with their disposable resources. For example, in welfare states such as Canada, after citizens have discharged their civic duties by paying their taxes, those individuals who can afford other luxury items such as high-end housing, gourmet food, and designer clothing are allowed to use their disposable income to purchase them. If they so choose, they may also go on a vacation or join a health club, both of which may enhance their well-being. However, it is unclear why opponents of multi-tiered systems treat non-basic health care differently from other luxury services. It seems that a state that allows its citizens to purchase various non-basic and possibly luxury services that are directly related to their well-being cannot consistently forbid them from buying non-basic health care in the private market. If taxpayers are allowed to purchase other non-basic goods even though not everyone can afford the same luxury, then by analogy those individuals who wish to purchase other uninsured health care services should be allowed to do so. For example, a patient with muscle injuries may purchase a Jacuzzi to help ease his minor muscle pain and hire a domestic helper to help him with housework. He may also want to purchase a massage chair that can provide additional relief. However, if individuals may purchase these services and products to improve their recovery chance and enhance their well-being, then they should also be allowed to purchase additional health care that may achieve the same purpose. For example, if a hospitalized patient would like to have her own private room, or if another patient with back injury would like to have daily massage in addition to his physiotherapy, respect for autonomy and the consistency argument require that they be allowed to purchase such services.

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[177] By disposable income, I mean the after-tax income. Given that the democratic state tries to protect the autonomy of its citizens, it has to refrain from charging its citizens too much tax or preventing them from using their after-tax income as they see fit.

Conceptual Difficulty and Practical Concern

The issue about how various services can all enhance well-being but are somehow available in the private market in the liberal state brings out one of the two other difficulties in preventing people from also purchasing uninsured health-care services in the private market. The first one is a conceptual issue. It seems that if the deliberative parties decide to allow people to purchase other goods and services but not various non-basic health-care services, they need to not only distinguish health-care from non health-care services but also point out why they are morally different. For example, in forbidding people from purchasing uninsured health-care services, we have to decide whether "health" clubs and spas are considered "health-care" services, and whether health-enhancing products such as better mattresses and pillows are also "health-care" products. We also need to determine the status of health-food stores that sell vitamins and so on. What makes this process of demarcation difficult is that, these establishments and products can contribute to one's well being and fitness. In fact, they may be considered "preventive" and "curative" measures in the sense that they can help those who purchase these services and products from getting sick or to recover faster. So the question is, how do we decide which of these facilities and products should be considered "health-care"? And for those services that are not considered "health-care," how do they morally differ from other services that also enhance people's well-being such that they should be available in the private market?

If we adopt the expansive notion of health as proposed by the World Health Organization, which defines health as "not merely the absence of disease but complete physical, mental, and social well being," it seems that almost any service that can enhance one's well being can be considered health care. This may create a problem for opponents of multi-tiered systems, because they will have to prohibit a wide variety of activities and establishments that can all enhance people's physical and mental well-being. Not only do we have to disallow people who are economically advantaged from taking yoga classes or buying an exercise machine, we will also have to forbid people from going on vacations. It seems that the deliberative parties who care about people's autonomy will probably not want to accept such restrictive regulations. Moreover, as I mentioned earlier, it is inconsistent for the deliberative parties that try to find ways to improve people's health status by establishing tax-funded health-care scheme to forbid people to purchase other services that may also improve their conditions.

One may argue that the deliberative parties do not have to accept the World Health Organization's broad definition of health. They may adopt a narrower understanding of health and health care and simply disallow people to purchase services that are considered health care. Putting aside the problem of deciding how broad or narrow this understanding of health care should be, it seems that even if we adopt a narrower understanding of health, we still have the difficulty of explaining why non-basic health care is morally different from other luxury goods and services. If all these services can enhance one's well-being and contribute to restoring people's opportunity range, why would calling something "health care" make it morally special such that we can prohibit people from purchasing it in the private market?

Besides the problem of demarcating non-basic health care from other luxury services and giving the former more moral weight, we also need to consider how far we are willing to go to prevent people from purchasing uninsured services. After all, there are private clinics and hospitals in many countries. If we want to prevent the rich from purchasing uninsured and possibly luxury services, do we want to stop them from going abroad to purchase such services? Unless the deliberative parties are prepared to also forbid each other from going out of the country, they simply cannot stop everyone who can afford private health care from purchasing various non-basic services.[178] The only difference will be *where* these people may purchase their services. So the question is how far we want to go to forbid people from buying uninsured services.

Purchasing Insured Services in the Private Market

Now the question is, if resources are scarce and the deliberative parties want to respect people's right to use their disposable resources, do they have to stop at allowing their fellow citizens to purchase uninsured services? In this section, I shall use the aforementioned arguments of basic equality, autonomy, and consistency to also support a second type of the multi-tiered system, which allows individuals to also purchase various publicly-funded health-care services in the private market. If a wealthy individual has paid her taxes to support a well-designed public tier, respect for her liberty demands that she should be allowed to purchase not only uninsured or luxury services but also insured health services in the private market. If purchasing private services does not harm others, it seems that the deliberative parties are unlikely to ban private medicine. They probably will have difficulty justifying to each other why people cannot use their disposable resources as they see fit, when their doing so does not harm others in the polity. The deliberative parties will realize that forbidding people to purchase insured services in the market may violate one of the goals of such a state, i.e., to protect and promote its citizens' freedom, especially if they have already contributed to the public tier. Monopolizing various insured services under the public sector and not allowing citizens to go outside the public system or practitioners to set up their own private facilities to serve their patients violate respect for people's autonomy and so probably will not be mutually agreed upon by the deliberative parties.

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[178] It may stop those in the middle and lower classes from doing so, but probably not those who are in upper income groups.

While this type of multi-tiered system may promote autonomy by allowing those who can afford private health care to purchase services "on their own terms," it is often attacked for its apparently inegalitarian implications. Some argue that while there may be good *prima facie* reasons for allowing individuals to purchase the same basic services in the private market, there are other moral reasons why such a system is overall unjustifiable. First, some argue that a supplementary tier is inconsistent with the principle of treating people with equal respect. They argue that such a tier is likely to lead to the problem of unequal access based on morally arbitrary factors. We can imagine that access to higher-quality services may depend not on needs but on one's ability to pay. For example, some worry that under a multi-tiered system the rich may be able to jump the queue and receive faster access to services that are rationed in the public sphere (Daniels; 1998). Such inequality in a democratic state seems problematic, because "allowing private resources to advantage people with something so basic as better functioning or more life undercuts our belief in the fundamental equality of persons" (Daniels, 1998, 34).[179] The private tier is considered a sign of disrespect for the equality of person (Daniels, 1998).

Second, opponents of multi-tiered systems worry about the effect of such a supplementary tier on the publicly-funded tier. They argue that the emergence of a private tier may undermine the provision of the best affordable health care to the public sector. So in the end the poor will be covered by a public insurance scheme that is severely restricted while the rich can enjoy a much wider range of high-quality procedures (Taft and Stewart, 2000).[180] For example, the presence of a supplementary tier may raise costs in the public sector, since the latter has to pay more to compete for doctors. At the same time, the presence of a private tier that provides quicker and better access may create considerable envy "that would undercut the sense of social solidarity needed to preserve the basic system" (Daniels, 1998, 33).

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[179] However, it seems that whether "better functioning" is problematic depends on whether such improvement actually translate into unequal opportunities.

I agree with these writers that people should not have to suffer from morally arbitrary factors, such as their social and economic positions. As I have argued, the deliberative parties would likely agree that the state should ensure that its citizens do not lose their fair equality of opportunity due to illnesses and injuries that they cannot afford to treat. I also agree that a legitimate system in a deliberative state has to give everyone equal respect and concern. In this way, if the presence of a private tier necessarily undermines equal respect for persons and the provision of affordable and quality health care in the public sector, then a multi-tiered system is objectionable. Now the question is whether multi-tiered systems that allow people to purchase insured services in the private market are guilty as charged.

Issues of Equality of Respect and Concern

I shall discuss the impact of the private system on the public system later in this chapter. In this section, let us examine the charge that the private tier in the multi-tiered system undermines our commitment to equality of persons (Daniels, 1998, 34). Some equate allowing people to have more rapid access to services with giving them moral priority and treating others with less respect. This is a serious charge, given that one of the goals of a democratic society is to achieve basic equality by minimizing the effects of undeserved disadvantages (and advantages). As Rawls (1971) says, the fundamental right to equal respect is owed to human beings as moral persons irrespective of their social positions. Ronald Dworkin (1977), who also is concerned with the fundamental right of being treated with equal concern and respect, similarly argues that the state "must not distribute goods or opportunities unequally on the ground that some citizens are entitled to more because they are worthy of more concern" (p. 273). Bearing in mind this requirement, it seems that one may argue that the deliberative parties simply cannot mutually agree on a health-care system that will undermine such commitment.

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[180] As we shall see later in this chapter, the success of Hong Kong's multi-tiered system in providing a wide range of high-quality services cast some doubt on the assumption that two-tiered systems necessarily result in the poor not receiving adequate care.

However, it is unclear exactly how a multi-tiered system that allows people to purchase insured services in the market is guilty as charged, ***when the publicly-funded tier does provide equal access to basic health care***. The tax-funded scheme provides access to everyone regardless of economic and social position. Such a scheme ensures that people do not have to suffer from various illnesses and injuries that may take away their normal functioning and opportunity, or affect their status as fully functioning citizens. The universal sphere is designed under the inclusive deliberative approach to guarantee equal concern and respect. It involves all the parties who may be affected by these decisions and considers their concerns and interests. By deliberating with each other in coming up with a system that is acceptable to all, the resulting scheme meets the reciprocity requirement and thus treats everyone with equal concern and respect. The parties all agree that the public sphere can fulfil the goals of establishing universal health care in the sense that this sector prevents and corrects various health problems that may diminish one's chance of achieving equality of opportunity.

If the publicly-funded tier effectively protects people from all social and economic positions from suffering from illnesses and injuries that may diminish their fair equality of opportunity, then it seems that the deliberative parties' obligation is fulfilled. There is no other obligation to ensure that some people cannot buy the same or additional services in the private market.[181]

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[181] Certainly, the deliberative parties can always decide to put more money in the health-care system, perhaps by charging more taxes or limiting other services. Putting aside some concerns I raised in previous chapters regarding both of these methods, it seems that

In order to understand why the commitment to fair opportunity and equality does not prohibit multi-tiered systems, we need to distinguish two different understanding of the requirement of equal concern and respect. First, there is the right to equal treatment, that is, "to the same distribution of goods or opportunities as anyone else has or is given" (Dworkin, 1977, 273). Second, there is the "right to treatment as an equal" (Dworkin, 1977, 273). This right requires that everyone's concerns be taken into account in making policy decisions.

As Dworkin argues, the right to treatment as an equal is the fundamental right under the liberal conception of equality, and is thus the notion of interest here.[182] This concept requires that people's concerns are given equal weight in the deliberative process, such that the poor's and the rich's interests are all being served.

I argue that once the parties have mutually agreed on the structure and design of the public tier, they have fulfilled the goal or requirement of promoting and protecting equal respect and concern. *As long as the public tier continues to serve the interests of all,* it fulfils the egalitarian commitment to promote and protect equal respect and concern. This commitment does not imply that we have to forbid those who can afford some level of private health care from purchasing it with their disposable resources. I do not deny that a multi-tiered system for basic health care implies unequal access in the *private* tier. However, I am not saying that those who can afford private health care are worthy of more concern. Rather, there are simply no legitimate reasons for restricting their freedom to use their disposable income as they see fit. We also need to bear in mind that unequal access by itself is not always problematic in a democratic state. If disparity in access does not translate into disparity in opportunity range, then unequal access to health-care resources is not illegitimate.

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we still have to deal with the budget constraint. In other words, the deliberative parties have to determine what level of health care to restore functioning and so on is legitimate within the budgetary limits. Once they have decided on the reasonable level of tax-funded health care, whatever that level may be, then it seems they have fulfilled their obligation.

[182] The more restrictive right to equal treatment, Dworkin (1977) argues, applies only in certain special circumstances, such as equal voting power.

Consistency Argument Revisited

Another problem of employing the argument of equal respect and concern to justify forbidding multi-tiered systems is that inequality in other sectors is allowed in a democratic state. Daniels (1998), for example, acknowledges that it is difficult to single out restriction on inequalities in health care. I have already argued that respect for people is preserved in a multi-tiered system that has a strong public tier that is agreed upon by all the deliberative parties. Even if for the sake of argument we join the opponents of multi-tiered systems in assuming that self-respect is somehow undercut when society endorses private health care, it is unclear that this concern applies only in the health-care scenario. For example, inequality in shelter creates differences in well-being and may have impact on people's self-respect. Other things such as education and food are also closely connected with basic well-being (Buchanan, 1991). Nonetheless, arguments against distribution inequalities that may undermine self-respect have not expanded into these areas. For example, Daniels seems to realize and accept the fact that the rich in most democratic societies are still allowed to use their economic resources to live much better lifestyles. Although his intuitive reaction is against tiering in health care, he realizes that we do allow disparity of living standard. In fact, people who are against multi-tiered systems in health care usually do not seem to think that we should also impose the same living standard on everyone. For example, they are not prepared to argue that we should all live in public housing, or that we ought to prohibit people from buying gourmet food or high-end housing, even though such "basic" but possibly better-quality items may enhance one's well-being and are only available to those who can afford them. At the same time, although education can significantly expand one's opportunity range and people with different educational levels often have varied opportunity ranges, most (if not all) liberals are not willing to argue that we should stop people from pursuing higher education if not everyone can afford to do so.[183] Perhaps these writers also realize that fellow citizens and the state have limited authority over what people may do with their expertise and disposable income. I agree that it is legitimate for the government to tax people to finance various social programs that are in common or shared interests. However, it is more problematic for the government to prohibit taxpayers from enhancing their well-being or further expanding their opportunity range *once they have fulfilled their obligation to support the public tier*. If my opponents believe that taxpayers should be allowed to purchase other higher-quality basic goods in the private market regardless of the fact that the poor may not have access to such goods, for the sake of consistency they have to agree that taxpayers should also be allowed to purchase insured health-care services in the private market.[184]

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[183] Perhaps one can argue that the consistency argument only shows that we should also disallow inequality in these other areas. In other words, we can simply forbid unequal access in not only health care, but also housing and education. While such a move can perhaps avoid the problem of inconsistency, one may question whether the deliberative

Effects of the Private System on the Public System

The second argument that opponents of multi-tiered systems employ is the argument of effect. Some argue that the emergence or the presence of a privately-funded tier can be detrimental on the publicly-funded system. Ron Pollock (1993), for example, argues that a single-tiered social insurance system creates a political constituency for high-quality health care that is unattainable in multi-tiered systems. The widely-held assumption is that, when the rich can purchase better-quality care in the private market, there would be less political pressure on politicians to maintain and improve the program. This can be worrying for the deliberative parties, since the end result may be a lower-quality tier for those who depend on the publicly-funded tier, and thus the poor may suffer from undeserved disadvantages and have difficulty achieving equality of opportunity. In other words, even if the deliberative parties initially agree on providing a range of services that are essential to protect people's fair equality of opportunity range, it is conceivable that when private health care is available

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parties will choose such a state that does not allow people to use their disposable income as they see fit.

[184] Daniels (1988) himself admits that there is something odd in restricting the strict egalitarian view to health-care systems. He acknowledges the concern that if we want to push toward stricter egalitarianism in a consistent way, we need to do so across the board.

the rich will start to withdraw their support for the public tier and refuse to contribute (Globerman and Vining, 1996; Pollock, 1993). Without their financial and political support, the public tier may not fulfil its goal of protecting the indigent from being disadvantaged by their health status and poor economic conditions.

Opponents of multi-tiered systems are also worried about the decreasing availability of affordable health-care workers in the public tier. They worry that the establishment of private facilities may bid health-care providers away from the publicly-financed sector, thereby creating shortages in the public sector (Taft and Stewart, 2000). If the public tier wants to compete with the private tier for good doctors, it will have to pay more, such that in the end the costs of services in the public tier will increase, undermining the possibility of providing affordable and high-quality health care in the long run. In this way, the presence of a private market may affect the strength of the public tier and its ability to protect people from suffering excessive and prolonged pain, losing fair equality of opportunity, or dying prematurely. Given the potentially detrimental effect of the private tier on the public tier, one may argue that my assumption that a multi-tiered system can maintain a strong universal public tier may collapse.

It is unclear that the effect of the presence of a private system on the public scheme is as straightforward as opponents of multi-tiered systems may believe.[185] It seems that how the supply and demand of health-care workers depends not on one simple factor but on multiple factors, such as the way citizens think of their commitment to the well-being of others, how doctors think of their role, and so on. Globerman and Vining (1996) do not deny the possibility that public facilities, which lose their position as monopolistic buyers of such services, may have to pay more for medical staff. However, they dispute the assumption that the emergence of private health care may bid the best health-care providers away from the public sector, thereby creating shortages in the public sector or leaving the less qualified practitioners in the public sector. They point out that the long-run supply of medical staff is relatively elastic (Globerman and Vining, 1996). In this way, it is unclear that there will be a shortage of doctors working in the public sector simply because of the presence of the private sector.

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[185] As we shall see later in this chapter, the presence of a private tier in Hong Kong has not compromised the services in the public tier.

Regarding the possibility of decreasing political and financial support for the public tier, it seems that whether those who are economically advantaged may stop supporting the public tier partly depends on the quality of care in this tier. If the services are of good quality, then the rich who have already paid towards such a tier would probably not want to pay extra and buy expensive services in the private tier.[186] As I have already argued, the deliberative parties probably will have mutually agreed on an adequate level of basic health care to be provided in the public sector. Granting this, the rich have good reasons to continue using and supporting this sector.[187] Even though the private tier may be present, there is no reason to think that the rich will totally abandon the public tier.

Globerman and Vining (1996) also point out that linkages between public and private financing efforts are very complex. First, they note that there has not been any comprehensive theoretical or empirical study on the public finance dynamics of a mixed health-care financing system. They caution those who simply assume that multi-tiered systems or the presence of private insurance *necessarily* lead to less political support and public financing, thereby lowering the quality of services provided in the public system. After all, the existence of a predominantly privately-funded system in Canada did *not* prevent the implementation of an essentially all publicly-funded program in 1960s. Even when increases in private expenditures on health care have taken place in Canada in recent years in part as a reaction to cost containment strategies in the public sector, the absolute increases in private expenditures have not led to decreases in public expenditures. While Globerman and Vining do not deny the possibility that public financing might have grown or expanded had private financing been unavailable, they are reluctant to accept the "simple argument that existing levels of funding under the public financing scheme will inevitably be eroded by allowing growth in private financing programs" (pp. 85-6).

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[186] For example, in places such as the United Kingdom and Hong Kong, many taxpayers who can afford to purchase private health care still continue to use the public system.

[187] One may question whether the private system can even survive if the public system is of high-quality and that the rich continue to use health-care services there. As we shall see later, perhaps those who are economically advantaged will visit the private facilities for minor health problems not because of better medical services but for convenience reasons or opportunity-cost reasons.

I argue that the ongoing inclusive deliberative process that I have proposed can also help sustain political support for the public tier. First, when all parties that are affected by allocation policies are involved in the decision process, the rich cannot dominate the decision-making process in such a way that the interests of the disadvantaged would be ignored by a multi-tiered system. As I have argued in the last two chapters, the resulting health-care system has to be mutually acceptable. In other words, it has to be approved not only by the dominant and majority groups but also by those who are in the minority groups. Such a process can help to ensure that various parties understand each other's needs and concerns and take into account such concerns in making allocation policies. Given that the voices of the indigent are heard and considered and that they are given the power to voice their concern, the inclusive deliberative process also helps to ensure that the resulting multi-tiered health-care system meets the requirement of equal concern and respect. Ongoing deliberation ensures that the emergence of a private tier does not compromise the quality of care in the public system such that it fails to fulfil the goals of establishing universal health care. The parties will regularly revisit the issues to make sure that the public system continues to protect people from suffering excessive pain, losing functioning and opportunity, and dying prematurely.

Second, when the parties deliberate to establish a health-care system that can protect shared or communal interests, the rich who see themselves as part of a community may be reluctant to ignore the needs of the impoverished. As I argued in chapter three, those who are economically advantaged may see themselves not as utility maximizers who have no connection to other citizens but as a member of the larger community. As such they may attach symbolic importance to joint effort in promoting a healthy population and in relieving the suffering of those in dire need. What they care about may not be simply whether they can purchase high-quality health care in the private market but whether fellow citizens also have access to essential services. After all, if the rich only cared about their own access, they could simply purchase private services in a pure market that provides no publicly-funded health care. However, I have argued that the deliberative parties, including the rich, will probably not adopt the pure market system. When people deliberate as fellow citizens who care about the welfare of each other, it is more likely that they will agree to support services that can improve the well-being of the indigent.

Third, as I have also argued in chapter three, the rich may enjoy various spillover effects from a healthy population, which justifies coercive redistribution to continue supporting the public tier. So regardless of whether they themselves are purchasing their own health care in the private market, they are obligated to contribute to the public tier. In other words, I argue that tax-cuts to reduce coverage for essential services in the public sector would probably not be approved by the deliberative parties.

Egalitarianism of Envy and Egalitarianism of Altruism

If a multi-tiered system does not violate the principle of equal respect and concern or compromise the quality of services provided by the public sector, it seems that there is little reason why the deliberative parties will want to prohibit the emergence of a private sector.

Some philosophers have argued that those who oppose a private market for insured services may hold an egalitarianism of envy in the sense that they may want to achieve equality by depriving those in better economic positions of possible benefits. It involves "cutting one person down to size in order to bring about that person's equality with another person who was in a previously disadvantageous position" (Nielsen, 1992, 109). As Engelhardt (1996) points out, an egalitarian of envy would prefer a world in which individuals are equal rather than some individuals having greater benefits. He or she may attempt to achieve equality by worsening the situation of those who are currently better off, regardless of whether that may benefit the least advantaged. This position suggests that it is legitimate to take away the advantage or benefit from those who have more so that they are levelled to the position of those who have less. In applying this principle to the health-care scenario, those who hold that an egalitarianism of envy is justified will prefer a system in which, everything else being equal, everyone has the same access rather than some people have greater access to health-care resources.

The question is, would the deliberative parties accept an egalitarianism of envy and thus disallow taxpayers from purchasing insured services in the private market? Perhaps not. As I argued before, while equality is one of the important values, it is not the only value shared among the people in the democratic state and thus they may not want to achieve strict egalitarianism at all costs. As autonomous beings, people in the democratic state also care about people's freedom to carry out their life plans as they see fit. They probably do not want the government or their fellow citizens to restrict their actions and life plans, so long as they do not harm others. In fact, respect and concern for their fellow citizens require that people should be allowed to carry out their own life plans, including how they may use their disposable resources. As Ronald Dworkin (1977) says, the government has to treat its citizens "as human beings who are capable of forming and acting on intelligent conceptions of how their lives should be lived" (p. 272). When we think about this concept of concern and respect in the deliberative framework, the deliberative parties have to treat others as rational beings who can decide for themselves how they should live their lives. When they think of others as rational agents who have their own interests and moral visions, they probably will not want to overly restrict what their fellow citizens may do with their resources. Moreover, the well-designed public tier ensures that everyone has access to essential health care and thus the citizens' interests are being promoted. This tax-funded tier that is agreed upon by all parties ensures that people do not have to suffer from excessive pain, loss of functioning and opportunity, and premature death. As long as their interests are protected, they would not disagree with a health-care scheme that allows taxpayers to purchase private health care.

Rawls (1971) believes that the contracting parties in a well-ordered society would not be strongly inclined to act or make decisions out of envy. As he argues, envy is disadvantageous to all. When we envy people in superior situation and are willing to deprive them of their greater benefits, these people in the better situation may become anxious to take precautions against the hostile acts that may result from such envy. In the end, envy is collectively disadvantageous, since the envious parties may do things to make everyone worse off so as to reduce the discrepancy.

Not only is envy against the people's rational self-interests because it may lead to poor results, I argue that the deliberative parties would probably not disallow their fellow citizens from buying private health care out of envy. The inclusive deliberative approach, which is designed to transform the way that people think about their relationship with each other, is likely to minimize ill-will among the deliberative parties, such that they would not make decisions out of envy. It is unlikely that they would reject multi-tiered systems because of some external preference, that is, "a preference for one assignment of goods or opportunities to others" (Dworkin, 1977, 275). After all, decisions that are based on external preferences discriminate those who are being constrained "precisely because their conception of a proper or desirable form of life is despised by others" (p. 276).

I argue that deliberative parties who care about each other's well being and try to find solutions or make policies that are mutually acceptable are likely to adopt the egalitarianism of altruism instead. This understanding of equality appeals to the sympathy of others to help those suffering (Engelhardt, 1996). This form of egalitarianism does not worry about whether some people have more than others. Rather, it is mainly concerned about whether some people suffer excessively or lose their fair opportunity range. It is not inequality *per se* that is problematic, but that some people's conditions are below a threshold level, since such poor conditions can take away people's chance to live autonomously as fully functioning citizens. A commitment to equality does not imply that we have to "even out" everyone's condition, but to improve the condition of those who are least advantaged. In trying to understand each other's concern and to find a way that can address people's needs, I argue that the deliberative parties would likely adopt egalitarianism of altruism as a principle in deciding what an acceptable health-care system should look like. In other words, they would try to provide necessary services to those who need them, but not to forbid the rich who might be able to from purchasing them in the private market.

Difference Principle and Multi-Tiered Systems

What the previous arguments imply is that liberal egalitarianism does not rule out the possibility of disparity. What affects the legitimacy of such disparity or inequality is whether it benefits the indigent, or at least does not disadvantage them further. I argue that the deliberative parties who care about autonomy and equality will likely adopt Rawls' (1971) difference principle in their deliberation. This principle is helpful because it provides the parties a way to evaluate the issue of inequality. As a liberal egalitarian, Rawls strives for equal basic liberty. However, this commitment does not stop him from adopting the difference principle, which allows inequality in resource distribution, if the inequality can benefit the least advantaged. What Rawls is interested in is whether such economic disparity or difference in access may benefit those who are worst off.

This principle implies that whether a multi-tiered system is justifiable depends, at least partly, on whether such a system may in fact benefit everyone, including those who cannot afford private health care.[188] As long as a multi-tiered system benefits everyone, such a system is not illegitimate. As Rawls (1971) says, social and economic inequalities are not inherently unjust. They are illegitimate only when such inequalities are not to the benefit of the least advantaged. In other words, the distribution of health-care resources need not be equal; it only has to be to everyone's advantage. [189] In fact, liberal egalitarians who give priority to the indigent may *prefer* an outcome that has greater inequality, if such inequality makes the impoverished better off (Temkin, 1993; Glannon, 1999).

With the difference principle or what Glannon (1999) calls the priority principle, what we are not trying to compare the position of the worse off to the well off in relative terms. In examining whether a multi-tiered system is beneficial to the least advantaged, we need to find out whether the emergence of a private tier would result in those who depend on the public tier being worse off or better off in absolute terms regarding the decent minimum. We need to examine how the indigent may fare in the public tiers of the single- and multi-tiered systems respectively. If tiering can help improve the condition of the worse off in the sense that the indigent may benefit more in the public tier of a multi-tiered system than in the public tier of a single-tiered system, the former system can be a legitimate way of distributing health care.

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[188] Larry Temkin (1993), for example, suggests that we should not attach weight to inequality *per se*. In cases where no one is made worse off by an unequal system, especially in those situations where everyone is better off in an unequal rather than equal system, it is at least plausible to say that the unequal system is better.

[189] Rawls (1971) adds an additional condition: that the principle of greatest equal liberty not be violated. This first principle of justice, which is lexically prior to the difference principle, requires that the principle of equal liberty has to be satisfied before we can consider the difference principle.

So, how may this work? Two arguments of efficiency support my view that the presence of a private market may be beneficial to the indigent. First, one may argue that the presence of a parallel private system can provide the public tier a point of comparison (Gratzer, 1999). The information collected in the private system relating to treatment utilizations, costs, and outcomes could pressure administrators in the public tier to watch their own results and motivate them to be more efficient and effective. Gratzer (1999), for example, calls this the "Federal Express method of health care reform" (p. 181). When consumers directly compare the costs of the same or similar services provided by both the courier and the post office, the latter has to be more accountable and find new ways to lower the costs of services. Similarly, when the profit-oriented private tier constantly tries to find more efficient ways to provide services, it forces the public system to also be more efficient.[190]

Second, if we allow the rich to purchase essential services in the private market, those who can afford various services may purchase them in private facilities, thereby shortening waiting lists in the public tier. This implies quicker services in the public tier for those who depend on it. Since there will be fewer people using the public tier, it also implies that more public resources can be spent on patients who do need or use the public system. So even though there is still unequal access in the private sector, a multi-tiered system can be justified on the ground that it raises the baseline position of the least advantaged.

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[190] It is also possible that the private system will try to bring out more advanced technologies that can extend life further or restore patients' functioning faster. Such advancements may lead to public pressure for funding more procedures. If we consider how the foldable lenses used in cataract surgeries in private facilities have pressured the Albertan government to fund such new treatment, it is conceivable that the public tier may improve along with the private tier.

However, one may question whether the emergence of a private system can in fact shorten waiting list. If I have already argued that the rich will still continue to support and use the public system that provides good-quality services, then the private system may not relieve the pressure on the public system.

I do agree that not every economically advantaged person will use the private system extensively. For example, they may still go to the public facilities for services that are more expensive, such as heart surgeries, cancer treatments, and so on. However, they may go to private clinics for other primary-care and less expensive services because of convenience and opportunity costs.[191] For example, they may go to the private clinic by their house or workplace for annual physical examination and minor illnesses and injuries. We can imagine that waiting time for publicly-funded clinics and other primary-care centres will shorten, and more resources can be spent on those who depend on the public system.[192]

The Hong Kong Example

There is also international evidence to support my argument that multi-tiered systems do not necessarily sacrifice the quality of services in the public sector. While the American system, which is often held up as the only counter-factual to a universal system, has got a bad name, multi-tiered systems do exist in other places such as Hong Kong and have received popular support. The citizens of Hong Kong all contribute to the tax-funded public tier, which provides universal access to various essential services. Alongside this public tier, there is also a private tier that provides some of the insured services and other additional services that are not covered by the public scheme.

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[191] Suppose an accountant earns $200 per hour. She may go to the public walk-in clinic, which is 15-minute drive from her house. Then she may have to wait for 45 minutes to see the doctor. Excluding the consultation time, this will take an hour, which means that the opportunity costs for her is $200. If she makes an appointment at the private clinic right across from her house, then she saves travelling and waiting time. If we assume that her visit to the clinic will cost her $100, she still 'saves' $100.

[192] Even if the private tier does not help the public tier such that the indigent are made *better* off under this system, as long as the public tier in both the single- and multi-tiered systems are comparable, both systems are equally justified.

The efficiency of Hong Kong's multi-tiered system is apparent from various indicators of health, such as life expectancy, maternal mortality rate, and infant mortality rate (Ho, 1997; Fan, 1999). What is interesting about this system is that, while Hong Kong's basic health care indicators compare favourably with developed Western countries, Hong Kong spends much less resources on health care. Hong Kong's private health expenditure assumes a much higher proportion of the total health expenditure (45.7%) than Canada (30.2%), Australia (30.6%), and the UK (15.9%), and the total health expenditures only add up to 4.6% of its GDP, which is substantially lower than most other industrialized countries, including Canada.[193] The public sector nonetheless manages to provide a decent minimum level of essential services to all, while the private sector provides some of the same and other additional services for those who can afford such services. While the private tier is established under the government's *laissez-faire* policy, as a whole the health-care system is relatively equitable in terms of access, utilization, resource distribution, and financing (Fan, 1999; Chun, 1999). Studies have shown that the quality of the publicly-funded tier is comparable to that of the private sector and is highly regarded by the public (Hsiao *et al*, 1999). In fact, in some sense the governmentally-funded tier in Hong Kong is often considered the better tier. Public hospitals, for example, are often better equipped than private hospitals. They are also under strict government regulations (Hsiao *et al*, 1999). Although there are more patients per room and also longer waiting time for non life-threatening treatments in the public hospitals compared to the private facilities, public hospitals in Hong Kong have more advanced equipment. Given that medical and technical experts are required to operate some of this equipment, public hospitals also have highly trained experts. While patients who use private facilities in Hong Kong do receive faster services, it is unclear that they are receiving "better" services, since patients in such public and private facilities have comparable mortality and morbidity rates. Results of a telephone survey in Hong Kong show that the population is generally satisfied with public hospitals, which scored higher in terms of "trust" and "environment within the hospital" than private hospitals.[194] As Lok San Ho points out (1997), a recent study conducted by the Census and Statistics Department in Hong Kong shows that 90% of patients admitted to public hospitals do not have any private insurance coverage precisely because they feel that they have already been effectively insured under the public tier. Although patients who cannot afford services at private facilities may have slower access to certain treatments compared to the rich, the general consensus in Hong Kong is that, at least for treatments for minor illnesses and injuries that are not too expensive, public-funded services should be reserved for the lower-income population. The citizens in Hong Kong also believe that the waiting lists would be much longer if the rich also join the queue in receiving 'free' services. In this way, the presence of a private tier for basic health care can help to improve the baseline condition of the impoverished.

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[193] For example, Canada and Australia spend 9.6% and 8.5% of their GDP on health expenditures respectively (Fan, 1999).

Two of the interesting and important implications of the Hong Kong example are worth noting here. First, recall that some worry that the rich will not want to pay taxes to support the public tier if they may simply purchase various sorts of health-care services in the private market. The Hong Kong example shows that this is not necessarily the case. The economically advantaged continue to support and use the public system for certain treatments. As I have mentioned, whether the rich will continue to support the public sector largely depends on how this tier performs. Certainly, if they perceive the public tier to be of unacceptable quality or it does not provide an adequate range of services, they may depend more heavily on the private system and also refuse to further support the public system. However, as long as the quality and quantity of services are reasonable in the public sector, it seems that the rich will continue to use and support it. The inclusive deliberative process, which ensures that the concerns of those who have to depend on the public tier will also be considered, is likely to maintain a good-quality public sector that will be supported not only by the poor but also the rich.

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[194] A total of 907 households were contacted and canvassed via the telephone for this survey conducted by the Survey and Research Programme of Lingnan College. For the questionnaire and findings, see Lok Sang Ho (1997).

The second concern regarding whether the rich will continue to support the public tier lies in the issue of whether we emphasize the importance of communal interests and health care as a public good. Julia Tao (1999) points out that one of the fundamental values underlying Hong Kong's health care system is a strong ethic of care and compassion. Although Tao does not describe the political process in Hong Kong as one of inclusive deliberation, she points out that this community cares deeply about social welfare, which is regarded not simply as some form of charity but as the community's wider effort to promote a fair and prosperous society and provide equal opportunities for all. Given such commitment to promote the welfare of all in the community, Hong Kong's multi-tiered health-care system has not led to the problem of reducing political support from the rich.

So it seems that allowing the rich to purchase private services does not necessarily compromise the government's duty to ensure that the citizens' health-care needs are met. In fact, it may be the better system for various population groups. First, it protects the interests of the lower-income groups by allowing them quicker access to essential services than in a single-tiered system. Second, it protects the liberty of the rich by allowing them to use their disposable resources as they see fit. In this way, unequal access in a well-designed multi-tiered system even for basic services can be acceptable to all deliberative parties. It seems that what may be problematic about some multi-tiered systems such as the American one is not the fact that the rich are allowed to purchase private insurance. Rather, as I have mentioned, the main reason why the least advantaged do not benefit under the American system is that the public tier does not provide universal access to basic health care or even adequate coverage for those who lack private insurance. When the government does not provide enough coverage for the least advantaged to ensure that they have an equal chance to obtain basic health care and meet their basic conditions, a private tier that allows the rich to get better care is unjustifiable. However, if the governmentally-financed tier provides essential or basic health care for all, including those who could not afford or obtain private insurance, the fact that the wealthy can purchase private insurance is not illegitimate. In other words, the main problem is not that we want to make sure that the rich cannot get private insurance. What we are appealing to is not strict egalitarianism or an egalitarianism of envy, which tries to achieve equality by lowering the status of the well-off. Rather, the goal is to achieve an egalitarianism of altruism, i.e., we want to achieve equality of basic condition by improving the status of the worse off. This goal can be obtained by providing comprehensive insurance for everyone, especially those who may not be able to afford coverage. In this way, the problem is not multi-tiered systems *per se*, but one that lacks a solid public tier that provides coverage for everyone who depends on it.

CONCLUSION

At the beginning of the thesis, I asked the question of whether we have a right to health care. I have argued that the notion of health-care rights is unhelpful in arguing for tax-funded health care. While the language of rights often has emotive force, it is too vague and confusing to provide a solid foundation for the argument for publicly-funded health care. However, the fact that rights language on its own cannot support tax-funded health care does not imply that we cannot find other reasons to support such redistributive scheme in a democratic state. I argued that, contrary to what libertarians believe, tax-funded health care does not necessarily violate people's autonomy. I argued that reflective citizens who deliberate with each other on various health-care schemes will realize that a tax-funded health-care system is in their interests. They will likely want a tax-funded system that provides various services that are necessary to prevent premature death, restore functioning and opportunity, prevent diseases and injuries, and ameliorate pain and suffering. I also argued that the deliberative parties would likely allow each other to purchase various health-care services in the private market.

Libertarians may question whether everyone in a pluralistic state will want such a centralized scheme. Putting aside the issue of redistribution, one may argue that some individuals may be reluctant to join a centralized health-care scheme. While they may initially want to participate in a cooperative scheme to acquire affordable health care, they may find that the mechanism necessary for such mega system is beyond individual control, and so the "cost" for getting "affordable" health care is simply too high. So even though they may have good intention and want to participate with each other to find the most affordable way to finance health care for everyone, they may doubt that a centralized state-funded scheme is the appropriate measure.

However, I contend that a centralized scheme in a deliberative democratic state can still be under its citizens' control. While a centralized health-care system in an undemocratic state may impose various regulations and policies on citizens without consulting them, reflective citizens in an inclusive deliberative state help shape the policies and allocation decisions. As I argued in chapters three and four, deliberations are carried out on the public level. In other words, citizens themselves reflect with each other face to face or through electronic media to deliberate on various issues that are important to them. They are also the legislators, since reflective citizens have to reach overlapping consensus on various policies before these policies can be implemented. By endorsing the empowerment criterion, the inclusive deliberative approach ensures that the citizens themselves have the power to shape and challenge various decisions. Such an approach allows citizens to oversee the operations of the system and continually find ways to address their respective concerns. It reminds the citizens that the system is self-imposed, i.e., it is established by the people and for the people.

One question that has not been addressed in this thesis is how far we can go with the deliberative approach. Throughout the thesis, I repeatedly said that the citizens should be the ones to deliberate with each other and make allocation and other political decisions. Nonetheless, I did not say anything about whether there should be a limit to deliberation. I did address at the beginning of the thesis whether people deliberate on the constitutional matters, i.e., the criteria for democracy. However, there is still the question of whether that is the only limit to deliberation. One may question if all decisions that result from the deliberative approach are legitimate. For example, can reflective citizens who employ the deliberative approach arrive at "wrong" results? Does my commitment to deliberative democracy imply that we should leave all judgements to the reflective citizens?

These are some of the questions that I hope to deal with thoroughly in the future. Without going into detail here, I propose that the decisions that result from a truly inclusive and deliberative approach are legitimate, whatever they may be. However, I do not deny the possibility that some "wrong" proposals that are against the democratic spirit may surface in the deliberation. When people initially get together, they may ignore the well-being of others and only concentrate on self-serving policies. However, since the constitutional framework specifies various constraints (i.e., the five criteria), policy suggestions that may be discriminatory or self-serving will in the end be severely scrutinized by all reflective citizens. With these constraints in place, it is difficult for discriminatory and unfair policies to be implemented.

While I am optimistic that the deliberative process that is undertaken by reflective citizens who treat each others as equals will come to conclusions which agree with my specific suggestions and proposals, I accept the possibility that the deliberative parties may arrive at different conclusions. There are two possible explanations for such potential deviations. First, it may be a sign that the deliberative parties may not have followed the constraints. For example, if the deliberative citizens decide that the state should not redistribute resources to establish universal health care, it may be a sign that the voices of the vulnerable have not been taken seriously. In other words, we may question whether the deliberative process is inclusive or whether those who are in powerful circumstances may have ignored the concern of the vulnerable groups.

There is a second possible explanation why my specific suggestions may differ from the results that are agreed upon by the deliberative parties. While I speculated what the deliberative citizens have good reasons to accept, my arguments and suggestions are not results of an inclusive deliberative approach. Rather, I applied various criteria of a deliberative democratic process to see how people might choose. But given that I did not deliberate with other fellow citizens face to face, it is possible that I may not have considered other viewpoints adequately, so that my suggestions do not address various interests equally. However, I do not think this possible discrepancy shows that the reflective process is illegitimate. Rather, it implies that personal contemplation may still not be enough to come up with suggestions that can be accepted by all. In other words, direct participation with others is necessary in coming up with political decisions that are mutually agreeable. If it turns out that the policies do not meet the criterion of, say, reciprocity, I simply have to engage in further discussions with other fellow citizens to make compromises that we can all accept.

In closing, I want briefly to discuss the application of deliberative democracy in the twenty-first century. As I mentioned throughout the thesis, many contemporary societies are not truly democratic. In most so-called liberal societies, citizens spend minimal time reflecting on various social issues and simply rely on elected officials to make decisions. Such reliance perpetuates the political disengagement. People continue to feel that they are political atoms that are separate from each other. Under representative government, people may think that they are not really part of the political process. After all, they are represented by a third party, i.e., elected politicians whom they may or may not have chosen. In this way, they may think that they themselves have no real power to challenge the political process. If we want to promote a truly democratic society in which people are engaged in reflection deliberation with their fellow citizens, we need to encourage citizens themselves to participate with each other in reaching agreements on policies. When they realize that they are all an integral part of the political process, they have good reasons to take deliberations seriously and try to find the best way to cooperate with each other.

I predict that various technological advances will play an increasing role in shaping the democratic process or promoting civic participation. Such inventions have already allowed people to connect with each other more easily. For example, electronic mail and internet allow people who live in different geographical areas to communicate with each other more frequently and in a timely fashion. Teleconferencing has also given people the chance to talk to each other "face to face" that might otherwise be impossible. They have therefore brought some people closer together. Various technologies also allow people to have easy access to various types of information and therefore help them to be more informed about the world surrounding them. It is reasonable to assume that these technologies will play even a bigger role in the future in informing people of various social concerns and allow them to deliberate with each other more effectively.

However, we must also be cautious of the possible side effects of these technologies. While many use these technologies to "stay connected," others are ironically using them to avoid having to deal with people directly. They use impersonal electronic mails to replace personal visits and phone calls. Various industries are also replacing human labour with electronic devices. For example, on-line voting systems have replaced personal interviews or face-to-face questionnaires. Bank machines have also replaced tellers. Distance or internet learning have also gained popularity, replacing traditional classroom learning. In the end, technologies may slowly replace human interactions, such that reflective citizens may feel more and more uncomfortable trying to deal with others.

A comprehensive examination of the effect that various new technologies may have on deliberative democracy is beyond the scope of this thesis, but I do hope to explore this area in the future. Such an examination is important for various reasons. First, as I just mentioned, since face-to-face deliberation may not always be possible because of geographical restrictions, various technologies may be necessary to facilitate inclusive deliberations. For example, televised deliberative discussions may help people from different parts of the country to learn their fellow citizens' perspectives. Second, as media play an increasing role in "informing" the public of various social and political issues, we need to examine whether the media are facilitating or hindering genuine democratic debates. As some social scientist have said, while the media can help people to form opinions and policy preferences, they can also fool the public. A comprehensive work on deliberative democracy therefore needs to look at the implications of mass media in modern democracy.

Bearing in mind that most liberal countries still fall short of being truly democratic, is it ever possible for people to become good deliberators who can discuss with their fellow citizens fairly and with an open mind? Would they even be willing to deliberate with each other? And what can we do, if anything, to promote deliberative democracy? I acknowledge that a comprehensive project on deliberative democracy has to address these issues. However, I can only make brief remarks about these issues at this point. While people may initially have difficulty in accepting the idea of deliberating with other fellow citizens, it is possible that over time they will be more informed about various issues and be more prepared to discuss with each other their concerns.[195] As social beings, they may develop a bond with other fellow citizens. Certainly, before people have thought about various issues, it is understandable that they may not know what to say to each other. However, just because people may not be able to act as ideal citizens from the outset does not imply that they should not work towards the ideal. As Aristotle says, moral virtue comes about by habit. In order for citizens to become good deliberators and thus good citizens, they have to engage in deliberation and learn from the process. Without actually practising and working towards being good deliberators, people will never become good deliberators.

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[195] For example, people who accept the libertarian doctrine may initially find it difficult to deliberate with other people. After all, libertarians do not think that they should have to justify to each other their viewpoints.

However, one may wonder what we can do with people who simply refuse to deliberate with their fellow citizens. Libertarians are against people forcing others to do anything, so they may be concerned about a "democratic" state that tries to force their citizens to participate in various policy-making processes. Although I am not prepared to coerce people to participate, for those who simply refuse to participate with each other, I am willing to say that they will have to accept the decisions "by default." If they are given the opportunity to express their concerns and challenge the decisions, then they cannot reject the results of the deliberation by arguing that they did not agree with those results. After all, if they do not voice their concerns, the deliberative parties cannot "guess" what may be their concerns. As social constructionists have warned us, in a pluralistic state we cannot presume people's interests and impose that standard on them. In other words, in order for us to understand others' concerns, they have to at least voice their concerns. So for those who refuse to participate, they either have to explain why they do not want to cooperate, or they have forfeited their chance of challenging the decisions.

While my thesis only concentrates on how the deliberative parties would decide on allocation, the inclusive deliberative approach I have argued for applies to more than health-care resource allocation. In fact, in order for citizens to be able to effectively adopt this mode of decision making in allocation issues, they have to employ such an approach in other areas of political lives. For example, they will have to deliberate with each other on how they want the education system to work, whether they want to fund the arts, and so on. Such deliberation can help citizens to work with each other as a social unit that tries to accommodate the needs of each other.

BIBLIOGRAPHY

Abberley, P. (1987). The Concept of Oppression and the Development of a Social Theory of Disability. Disability, Handicap and Society, 2(1), 5-19.

Arneson, R. (1982). The Principle of Fairness and Free-Rider Problems. Ethics 92, 616-633.

Bayles, M. (1981). Justice and the Dying. In E. Shelp (Ed.), Justice and Health Care (pp. 109-120). Dordrecht: D. Reidel Publishing Company.

Beauchamp, T. (1991). The Right to Health Care in a Capitalistic Democracy. In T. J. Bole III and W. B. Bondeson (Eds.), Rights to Health Care (pp. 53-82). Netherlands: Kluwer Academic Publishers.

Benditt, T. (1982). Rights. Totawa, NJ: Rowman and Littlefield.

Bohman, J. (1996). Public Deliberation: Pluralism, Complexity, and Democracy. Cambridge, Mass.: MIT Press.

Bohman, J., Cohen, C., & Rehg, W. (1997). (Eds.) Deliberative Democracy: Essays on Reason and Politics. Cambridge, Mass.: MIT Press.

Bole III, T. J. (1991). The Rhetoric of Rights and Justice in Health Care. In T. J. Bole III and W. B. Bondeson (Eds.), Rights to Health Care (pp. 1-22). Netherlands: Kluwer Academic Publishers.

Braybrooke, D. (1987). Meeting Needs. Princeton, N.J.: Princeton University Press.

Brody, B. (1991). Why the Right to Health Care is Not a Useful Concept for Policy Debates. In T. J. Bole III and W. B. Bondeson (Eds.), Rights to Health Care (pp. 113-134). Netherlands: Kluwer Academic Publishers.

Buchanan, A. (1991). Rights, Obligations, and the Special Importance of Health Care. In T. J. Bole III and W. B. Bondeson (Eds.), Rights to Health Care (pp. 169-184). Netherlands: Kluwer Academic Publishers.

Callahan, D., & Hanson, M. (1999). (Eds.) The Goals of Medicine: The Forgotten Issue in Health Care Reform. Washington, D. C., Georgetown University Press.

Childress, J. (1981). Priorities in the Allocation of Health Care Resources. In Earl Shelp (Ed.), Justice and Health Care (pp. 139-150). Dordrecht: D. Reidel Publishing Company.

Churchill, L. (1994). Self-Interest and Universal Health Care: Why Well-Insured Americans Should Support Coverage for Everyone. Cambridge, Mass.: Harvard University Press.

Copp, D. (1992). The Right to an Adequate Standard of Living: Justice, Autonomy, and the Basic Needs. In E. Paul, F. Miller, and J. Paul (Eds.), Economic Rights. Cambridge: Cambridge University Press.

Copp, D. (1998). Equality, Justice, and the Basic Needs. In Gillian Brock (Ed.), Necessary Goods: Our Responsibilities to Meet Others' Needs (pp. 113-134). Lanham, MD: Rowman & Littlefield Publishers, Inc.

Daniels, N. (1983). Health Care Needs and Distributive Justice. Iin R. Bayer and A. Caplan (Eds.), In Search of Equity: Health Needs and the Health Care System (pp. 1-42). New York: Plenum Press.

Daniels, N. (1985). Just Health Care. Cambridge: Cambridge University Press.

Daniels, N. (1991). Equal Opportunity and Health Care Rights for the Elderly. In T. J. Bole III and W. B. Bondeson (Eds.), Rights to Health Care (pp. 201-212). Netherlands: Kluwer Academic Publishers.

Daniels, N. (1992). Justice and Health Care Rationing: Lessons from Oregon. In M. Strosberg, J. Wiener, R. Baker, and A. Fein (eds.), Rationing America's Medical Care: The Oregon Plan and Beyond (pp. 185-196). Brookings Dialogues on Public Policy. Washington, D. C., The Brookings Institution.

Daniels, N. (1998). Symposium on the Rationing of Health Care: 2 Rationing Medical Care -- A Philosopher's Perspective on Outcomes and Process. Economics and Philosophy, 14, 27-50.

Daniels, N. (1999). Enabling Democratic Deliberation: How Managed Care Organizations Ought to Make Decisions about Coverage for New Technologies. In S. Macedo (Ed.), Deliberative Politic: Essays on Democracy and Disagreement (pp. 198-210). Oxford: Oxford University Press.

Daniels, N. (2000). Normal Functioning and the Treatment-Enhancement Distinction. Cambridge Quarterly of Healthcare Ethics, 9(3), 309-322.

Doyal, L. (1998). A Theory of Human Need. In G. Brock (Ed.), Necessary Goods: Our Responsibilities to Meet Others' Needs (pp. 157-172). Lanham, MD: Rowman & Littlefield Publishers.

Doyal, L. and Gough, I. (1991). A Theory of Human Need. Hamspshire: MacMillan.

Dworkin, G. (1983). Paternalism. In J. Kleining (Ed.), Paternalism (pp. 19-34). Landman, MD: Rowman & Littlefield Publishers, Inc.

Dworkin, R. (1977). Taking Rights Seriously. Cambridge: Harvard University Press.

Elkin, S., & Soltan, K. (1999). (Eds.). Citizen Competence and Democratic Insitutions. University Park, PA: The Pennsylvannia State University Press.

Engelhardt, H. T. (1991). "Rights to Health Care: Created, Not Discovered. In T. J. Bole III and W. B. Bondeson (Eds.), Rights to Health Care (pp. 103-112). Netherlands: Kluwer Academic Publishers.

Engelhardt, H. T. (1992). Why a Two-Tier System of Health Care Delivery Is Morally Unavoidable. In M. Strosberg, J. Wiener, R. Baker, and A. Fein (Eds.), Rationing America's Medical Care: The Oregon Plan and Beyond (pp. 196-207). Brookings Dialogues on Public Policy. Washington, D. C., The Brookings Institution.

Engelhardt, H. T. (1996). The Foundations of Bioethics. Second Edition. Oxford: Oxford University Press.

English, J. (1979). What Do Grown Children Owe Their Parents? In O. O'Niell and W. Ruddick (Eds.), Having Children: Philosophical and Legal Reflections on Parenthood (pp. 351-359). New York: Oxford University Press.

Fan, R. (1999). Freedom, Responsibility, and Care: Hong Kong's Health Care Reform. Journal of Medicine and Philosophy, 24(6), 555-570.

Feinberg, J. (1973). Social Philosophy. Englewood, NJ: Prentice Hall.

Feinberg, J. (1979). The Nature and Value of Rights. In D. Lyons (Ed.), Rights (pp. 78-91). Belmont, CA: Wadsworth Publishing Company, Inc.

Feinberg, J. (1980). Rights, Justice, and the Bounds of Liberty: Essays in Social Philosophy. Princeton, New Jersey: Princeton University Press.

Fish, S. (1999). Mutual Respect as a Device of Exclusion. In S. Macedo (Ed.), Deliberative Politics: Essays on *Democracy and Disgreement* (pp. 88-102) Oxford: Oxford University Press.

Fishkin, J. (1995). The Voice of the People: Public Opinion and Democracy. New

Haven: Yale University Press.

Fishkin, J. (1999). Toward Deliberative Democracy: Experimenting with an Ideal. In S. Elkin and K Soltan (Eds.), Citizen Competence and Democratic Institutions (pp. 279-290). University Park, PA: The Pennsylvania State University Press.

Fitzgerald, R. (1977). The Ambiguity and Rhetoric of 'Need'. In Ross Fitzgerald (Ed.), Human Needs and Politics. Rushcutters Bay: Pergamon Press.

Frankfurt, H. (1998). Necessity and Desire. In G. Brock (ed.), Necessary Goods: Our Responsibilities to Meet Others' Needs (pp. 19-32). Lanham, MD: Rowman & Littlefield Publishers, Inc.

Fraser, N. (1989). Unruly Practices: Power, Discourse, and Gender in Contemporary Social Theory. Minneapolis, MN: University of Minnesota Press.

Galston,W. (1991). Liberal Purposes: Goods, Virtues, and Diversity in the Liberal State. Cambridge: Cambridge University Press.

Galston, W. (1999). Diversity, Toleration, and Deliberative Democracy: Religious Minorities and Public Schooling. In S. Macedo (Ed.), Deliberative Politics: Essays on *Democracy and Disagreement* (pp.39-48). Oxford: Oxford University Press.

Gaulthier, D. (1990). Moral Dealing: Contract, Ethics, and Reason. Ithaca: Cornell University Press.

Gewirth, A. (1996). The Community of Rights. Chicago: The University of Chicago Press.

Glannon, W. (1998). Responsibility, Alcoholism, and Liver Transplantation. Journal of Medicine and Philosophy, 23 (1), 31-49.

Glannon, W. (1999). Diamond and Daniels on Medical Rationing. Economics and Philosophy, 15, 119-125.

Globerman, S. and Vining, A. (1996). Cure or Disease: Private Health Insurance in Canada. Toronto: University of Toronto Press.

Goodin, R. (1985). Protecting the Vulnerable: A Reanalysis of Our Social Responsibilities. Chicago: The University of Chicago Press.

Goodin, R. (1988). Reasons for Welfare: The Political Theory of the Welfare State.

Princeton, New Jersey: Princeton University Press.

Goodin, R. (1990). Relative Needs. In A. Ware and R. Goodin (Eds.), Needs and Welfare (pp. 12-33). SAGE Modern Politics Series Volume 26. London: SAGE Publications Ltd.

Gratzer, D. (1999). Code Blue: Reviving Canada's Health Care System. Toronto: ECW Press.

Green, R. (1976). Health Care and Justice in Contract Theory Perspective. In R. Veatch and R. Branson (Eds.), Ethics and Health Policy (pp. 111-126). Cambridge, Mass.: Ballinger Publishing Co.

Green, R. (1983). The Priority of Health Care. Journal of Medicine and Philosophy, 8, 373-380.

Gutman, A. (1983). For and Against Equal Access to Health Care. In R. Bayer and A. Caplan (Eds.), In Search of Equity: Health Needs and the Health Care System (pp. 43-68). New York: Plenum Press.

Gutmann, A. & Thompson, D. (1996). Democracy and Disagreement. Cambridge, Mass.: Belknap Press.

Hacking, I. (1999). The Social Construction of What? Cambridge, Mass.: Harvard University Press.

Halper, T. (1991). Rights, Reforms, and the Health Care Crisis: Problems and Prospects. In T. Bole (Ed.), Rights to Health Care (pp. 135-168). Dordrecht: Kluwer Academic Publishers.

Hart. H. L. A. (1979). Are There Any Natural Rights? In David Lyons (Ed.), Rights (pp. 14-25). Belmont, CA: Wadsworth Publishing Company, Inc.

Harvard Team, The. (1999). Improving Hong Kong's Health Care System: Why and For Whom? Report published by the Health and Welfare Bureau.

Hayek, F. (1978). The Constitution of Liberty. Phoenix Edition. Chicago: University of Chicago Press.

Ho, L. (1997). Health Care Delivery and Financing: A Model for Reform. Hong Kong: City University of Hong Kong Press.

Hospers, J. (1992). The Libertarian Manifesto. In J. Sterba (Ed.), Justice: Alternative

Political Perspectives (pp. 41-53). Belmont, CA: Wadsworth Publishing Company.

Jones, G. (1983). The Right to Health Care and the State. The Philosophical Quarterly 33 (132), 279-287.

Kaufmann, A. (1999). Welfare in the Kantian State. Oxford: Oxford University Press.

Kymlicka, W. (1990). Contemporary Political Philosophy: An Introduction. Oxford: Clarendon Press.

Lyons, D. (1979a). (Ed.). Rights. Belmont, CA: Wadsworth Publishing Company, Inc.

Lyons, D. (1979b). Rights, Claimants, and Beneficiaries. In D. Lyons (Ed.), Rights (pp. 58-77). Belmont, CA: Wadsworth Publishing Company, Inc.

Lyons, D. (1979c). Human Rights and the General Welfare. In D. Lyons (Ed.), Rights (pp. 174-186). Belmont, CA: Wadsworth Publishing Company, Inc.

Machan, T. (1989). Individuals and Their Rights. La Salle, IL: Open Court.

Margolis, J. (1978). Reflections on the Right to Health Care. In E. Bandman and B. Bandman (Eds.), Bioethics and Human Rights: A Reader for Health Professionals (pp. 354-359). Boston: Little, Brown and Company.

Menzel, P. (1983). Medical Costs, Moral Choices: A Philosophy of Health Care Economics in America. New Haven: Yale University Press.

Mill, J. S. (1974). On Liberty. London: Penguin Books. (Original work published 1859)

Moskop, J. (1983). Rawlsian Justice. Journal of Medicine and Philosophy 8, 329-338.

Moss, A. & Siegler, M. (1991). Should Alcoholics Compete Equally for Liver Transplantation? Journal of American Medical Association 265 (10), 1295-8.

Nagel, T. (1981). Libertarianism Without Foundations. In R. Wolff (Ed.), Reading Nozick: Essays on Anarchy, State, and Utopia (pp. 191-205). Totowa, NJ: Rowman & Littlefield.

Narveson, J. (1988). The Libertarian Idea. Philadelphia: Temple University Press.

Narveson, J. (1993). Moral Matters. Peterborough, Ontario: Broadview Press.

Nielsen, K. (1984). Equality and Liberty: A Defense of Radical Egalitarianism. Totowa, NJ: Rowman & Allanheld Publishers.

Nielsen, K. (1992). Radical Egalitarianism. In J. Sterba (Ed.), Justice: Alternative Political Perspectives. Belmont, CA: Wadsworth Publishing Company.

Nickel, J. (1987). Making Sense of Human Rights: Philosophical Reflections on the Universal Declaration of Human Rights. Berkeley: University of California Press.

Nozick, R. (1974). Anarchy, State, and Utopia. New York: Basic Books.

Nozick, R. (1989). The Examined Life. New York: Simon & Schuster, A Touchstone Book.

Nozick, R. (1993). The Nature of Rationality. Princeton, NJ: Princeton University Press.

Nussbaum, M. (1992). Human Functioning and Social Justice: In Defense of Aristotelian Essentialism. Political Theory, 20 (2), 202-246.

Nussbaum, M. (1995). Aristotle on Human Nature and the Foundations of Ethics. In J. E. Altham and R. Harrison (Eds.), World, Mind, and Ethics: Essays on the Ethical Philosophy of Bernard Williams (pp. 86-131). Cambridge: Cambridge University Press.

O'Day, D. (1997). Do You Need Cataract Surgery? The Physician's Perspective. Retrieved on July 28, 2000 from the World Wide Web: http://onhealth.webmd.com/conditions/in-depth/item/item,2428_1_1.asp

Oliver, M. (1990). The Politics of Disablement. Basingstoke: Macmillan.

O'Neill, O. (1986). Faces of Hunger: An Essay on Poverty, Justice, and Development. London: Allen & Unwin.

O'Neill, O. (1996). Towards Justice and Virtue: A Constructive Account of Practical Reasoning. Cambridge: Cambridge University Press.

O'Neill, O. (1998). Rights, Obligations, and Need. In G. Brock (Ed.), Necessary Goods: Our Responsibilities to Meet Others' Needs (pp. 95-112). Lanham, MD: Rowman & Littlefield Publishers, Inc.

Pellegrino, E. (1999). The Goals and Ends of Medicine: How Are They to be Defined? In D. Callahan and M. Hanson. (Eds.), The Goals of Medicine: The Forgotten

Issue in Health Care Reform (pp. 55-67). Washington, D. C., Georgetown University Press.

Pollock, R. (1993). Eleven Lessons from Canada's Health Care System. In A. Bennett and O. Adams (Eds.), Looking North for Health: What We Can Learn from Canada's Health Care System (pp. 142-176). The Jossey-Bass Health Series. San Francisco: Jossey-Bass Publishers.

Rachlis, M. & Kushner, C. (1994). Strong Medicine: How to Save Canada's Health Care System. Toronto: Harper Collins Publishers Ltd.

Ramsay, M. (1992). Human Needs and the Market. Hants: Avebury.

Ramsey, P. (1970). The Patient as Person. New Haven: Yale University Press.

Rawls, J. (1971). A Theory of Justice. Cambridge: Harvard University Press, Belknap Press.

Rawls, J. (1993). Political Liberalism. New York: Columbia University Press.

Rhoden, N. (1991). Free Markets, Consumer Choice, and the Poor: Some Reasons for Caution. In T. Bole, III and W. Bondeson, Right to Health Care (pp. 213-241). Netherlands: Kluwer Academic Publishers.

Sandel, M. (1998). Liberalism and the Limits of Justice. Second edition. Cambridge: Cambridge University Press.

Sass, J. (2000a). Curing Health Care: Cuts and Consequences -- Coping with Change. Retrieved July 28, 2000 from the World Wide Web: http://www.cbc.ca/news/indepth/healthcare/cuts_consequences.html

Sass, J. (2000b). Curing Health Care: Today's Pain, Tomorrow's Gain? Retrieved July 28, 2000 from the World Wide Web: http://www.cbc.ca/news/indepth/healthcare/todays_pain.html

Shaklar, J. (1991). American Citizenship: The Quest for Inclusion. Cambridge, Mass.: Harvard University Press.

Scheman, N. (1993). Engenderings: Constructions of Knowledge, Authority, and Privilege. New York: Routledge.

Shue, H. (1980). Basic Rights: Subsistence, Affluence and U.S. Foreign Policy. Princeton, NJ: Princeton University Press.

Sidel, V. (1978). The Right to Health Care: An International Perspective. In E. Bandman and B. Bandman (Eds.), Bioethics and Human Rights: A Reader for Health Professional (pp. 341-350). Boston: Little, Brown and Company.

Singer, P. (1976). Freedoms and Utilities in the Distribution of Health Care. In R. Veatch and R. Branson (Eds.), Ethics and Health Policy (pp. 175-193). Cambridge, Mass.: Ballinger Publishing Company.

Singer, P. (1990). Animal Liberation. New York: New York Review of Books.

Shapiro, I. (1999). Enough of Deliberation: Politics Is about Interests and Power. In S. Macedo (Ed.), Deliberative Politics: Essays on *Democracy and Disagreement* (pp. 28-38) Oxford: Oxford University Press.

Smith, P. (1998). Liberalism and Affirmative Obligation. New York: Oxford University Press.

Strosberg, M., Baker, R., Wiener, J., and Fein, A. (1992). (Eds.). Rationing America's Medical Care: The Oregon Plan and Beyond. Washington, D.C.: Brookings Institution.

Sugden, R. (1993). Thinking as a Team: Towards an Explanation of Nonselfish Behavior. Social Philosophy and Policy 10 (1), 66-89.

Sumner, L. (1987). The Moral Foundation of Rights. Oxford: Clarendon Press.

Susser, M. & Watson, W. (1971). Sociology in Medicine. London: Oxford University Press.

Tao, J. (1990). Does it Really Care? The Harvard Report on Health Care Reform for Hong Kong. Journal of Medicine and Philosophy, 24 (6), 571-590.

Taylor, C. (1989a). Cross Purposes: The Liberal-Communitarian Debate. In N. Rosenblaum (Ed.), Liberalism and the Moral Life (pp. 159-182). Cambridge, Mass.: Harvard University Press.

Taylor, C. (1989b). Sources of the Self: The Making of the Modern Identity. Cambridge, Mass.: Harvard University Press.

Temkin, L. (1993). Inequality. Oxford: Oxford University Press.

Thomson, G. (1987). Needs. London: Routledge & Kegan Paul.

Thompson, J. (1977). Some Ruminations on Rights. Arizona Law Review, 19, 45-60.

Tierney, B. (1997). The Idea of Natural Rights. Atlanta, GA: Scholars Press.

Tuck, R. (1979). Natural Rights Theories: Their Origin and Development. Cambrdige: Cambridge University Press.

U. S. Department of Commerce. (September, 1998). Current Population Reports: Health Insurance Coverage: 1997.

Veatch, R. (1991). Justice and the Right to Health Care: An Egalitarian Account. In T. J. Bole III and W. B. Bondeson (Eds.), Rights to Health Care (pp. 83-102). Netherlands: Kluwer Academic Publishers.

Weinreb, L. (1992). Natural Law and Rights. In R. George (Ed.), Natural Law Theory: Contemporary Essays. Oxford: Clarendon Press.

Wellman, C. (1982). Welfare Rights. Totowa, NJ: Rowman and Littlefield.

Wiggins, D. (1991). Needs, Values, Truth. Second Edition. Oxford: Basil Blackwell Ltd.

Wiggins, D. (1998). What Is the Force of the Claim That One Needs Something? In G. Brock (Ed.), Necessary Goods: Our Responsibilities to Meet Others' Needs (pp. 35-56). Lanham, MD: Rowman & Littlefield Publishers.

Wolgast, E. (1987). The Grammar of Justice. Ithaca: Cornell University Press.

World Health Organization. (1958). Preamble to the Constitution. In The First Ten Years of the World Health Organization. Geneva: The Organization.

Young, I. (1990). Justice and the Politics of Difference. Princeton, New Jersey: Princeton University Press.

Young, I. (1997). Feminism and the Public Sphere: Asymmetrical Reciprocity. Constellation: An International Journal of Critical and Democratic Theory 3 (3), 340-363.

Young, I. (1999). Justice, Inclusion, and Deliberative Democracy. In S. Macedo (Ed.), Deliberative Politics: Essays on *Democracy and Disagreement* (pp. 151-158). Oxford: Oxford University Press.